Republic of Botswana

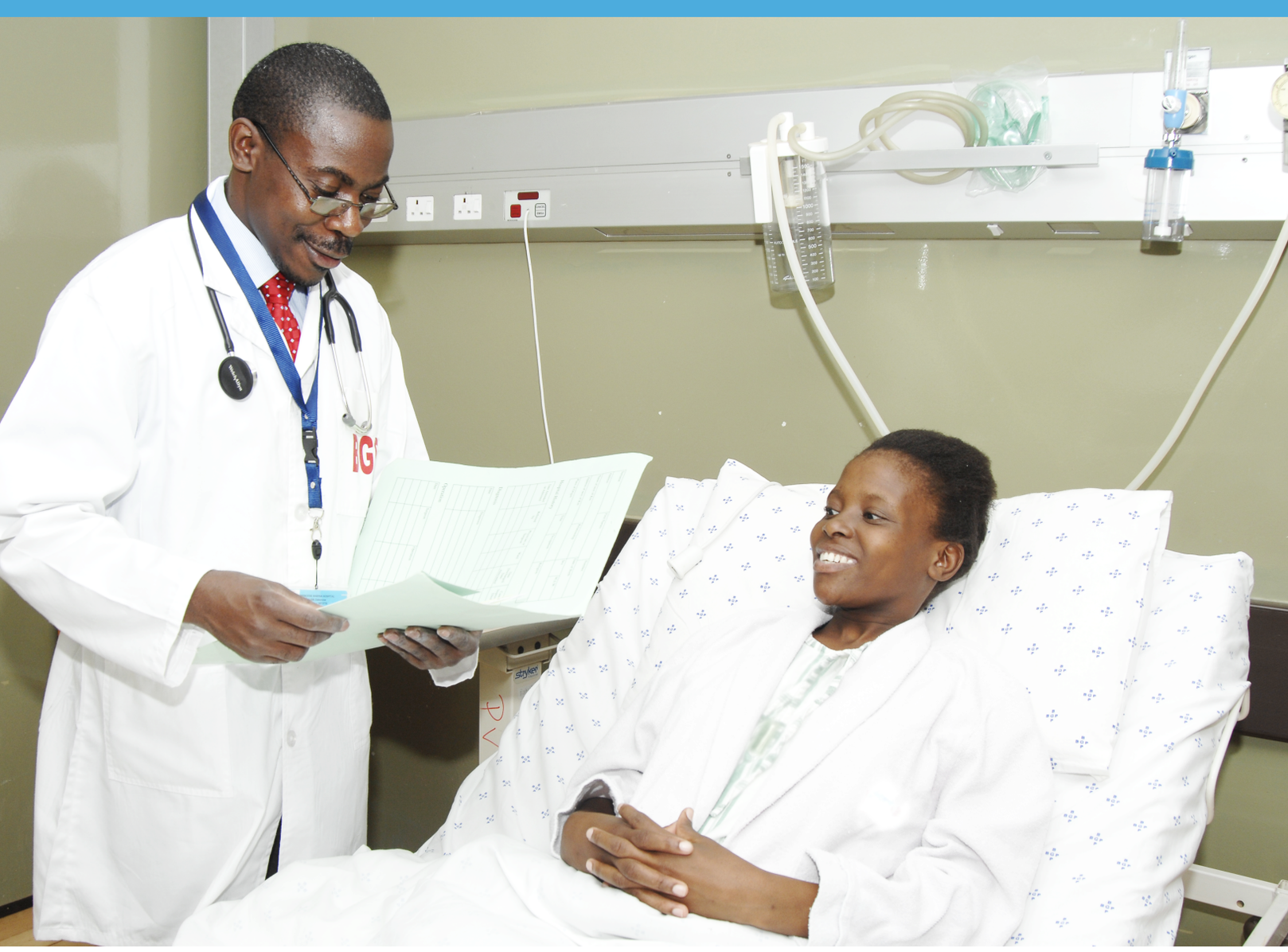
National Health Quality Standards

Standards & Guidelines for Hospitals

"Diagnostic, Care and Treatment Support Services"

Volume 2

Improving Quality & Safety of Health Services



National Health Quality Standards

Standards & Guidelines
For Hospital Standards
Volume 2

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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 Health Care
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.)*
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.
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 settig. 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.
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 Health Care	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 Health Care 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 sub-acute 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 sub-acute 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 governance structure is	The first criterion in this section for standard 1.1.1

described in written documents, which are known to the staff in the organisation	
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 none 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.

Criterion10.8.1.1:There is a written quality improvement programme for the service that is developed and agreed upon by the personnel of the service.

Criterion10.8.1.3: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 health care 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 country 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 health care professionals who are allowed to render patient care, regardless of their employment status.

SE 10 GENERAL MEDICAL /SURGICAL/PAEDIATRIC AND OBSTETRIC CARE

OVERVIEW OF GENERIC STANDARDS

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and co-ordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, laws and regulations, an individual's particular skills, knowledge and experience, and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medication, supportive therapies, or a combination of these. A care plan is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Continuity of care:
From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation.

Processes for continuity and Coordination of care among medical practitoners, nurses and other health service providersmust be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure Coordination of care.

Standards

10.1 Coordination of Patient Care

10.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

10.1.1 Criteria

10.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers, i.e. doctors and nurses.
Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists.

It is important to assess the availability of doctors, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

10.1.1.2 The individuals responsible for the patient's care are qualified.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels, bed occupancy levels, etc.

The level of qualifications required would be dependent on the category of the relevant hospital, for example, a qualified general registered nurse with supervisory or management experience could be suitable as a ward manager) in a small district level hospital, while a referral level hospital would need a registered nurse with advanced nursing as well as management qualifications.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
10.4.1.2, 10.6.1.1, 10.6.2.1

10.1.1.3 The individuals responsible for the patient's care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times.
Patient interviews *will reveal whether staff members introduced themselves to patients.*

Linked criterion:
10.5.3.3

10.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

10.1.2 Criteria

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

Root criterion

This refers to the relevant forms/documents that need to be present in the patient file, 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 relevant criteria in this document.*

Linked criterion:
1.3.2.4

10.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (doctors, nurses, professions allied to medicine, social workers, etc) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record.

Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information Compliance will be verified during the ***patient record audit.****If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.*

10.1.2.3 Information exchanged includes a summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criterion:
10.5.1.1

10.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

10.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.
Methods of verifying signatures and designations could include:

- *names and designations printed below signatures*
- *stamps indicating names and designations and/or*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

10.1.2.6 The date of each patient record entry can be identified.

Records must follow a chronological order to allow for a logical flow of information. Compliance will be verified during the ***patient record audit.***

10.1.2.7 The time of each patient record entry can be identified.

Patient records include time of arrival at the facility and each time that the patient is assessed by a health professional.
Compliance will be verified during the ***patient record audit.***

10.2 Facilities and Equipment

10.2.1 Adequate resources are available for the provision of safe care to patients in the ward.

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate toilet and bathing facilities for the number of patients in the ward, as determined by nationallegislation.

Each delivery room has at least:

- one cardio-tocograph machine
- an infant warming and resuscitation cart
- an incubator with adjustable temperature and separate oxygen supply
- a fetal monitor
- equipment for inhalation analgesia
- There is a temperature-controlled nursery and it has
- suitable bassinettes
- photo-therapy lights
- a panel for viewing babies
- a designated area for preparing infant feeds
- a fridge for milk feeds only
- facilities allocated for washing utensils used when preparing infant feeds.

There is adequate lighting and ventilation.

Nurse call systems are available at bedsides and in bathrooms and toilets and are connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in

place and working satisfactorily. Each ward is provided with a socket outlet that is connected to the emergency power supply.

A resuscitation trolley is available at the point of need within 1 minute. In addition, there is access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any patient collapsing. Resuscitation equipment includes at least:

- a defibrillator with adult paddles / pads (and infant paddles / pads where applicable)
- an ECG monitor
- a CPR board (if required)
- suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- a bag-mask manual ventilator
- a range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable
- an introducer /stylet for endotracheal intubation
- a syringe to inflate the ETT cuff
- oropharyngeal tubes
- equipment to perform an emergency cricothyroidotomy – (needle and surgical)
- appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
- plasma expanders.

10.2.1 Criteria

10.2.1.1 Patient and staff accommodation and equipment is adequate to meet patient care needs.

Root criterion.

There should be adequate office space for personnel; clean, hygienic sluice rooms, treatment and dressing rooms; demonstration rooms, adequate, tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients, as well as the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6
29.2.1.1

10.2.1.2 Oxygen and vacuum supplies meet the needs of patients for care.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. There must also be enough functional flow-meters.

Any evidence of infection control deficiencies e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9 (Prevention and Control of Infections).

Linked criteria:
29.2.2.1, 29.2.3.2

10.2.1.3 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture

Linked criterion:
31.2.1.5

10.2.1.4 Resuscitation equipment is available in accordance with the policies of the organisation.

Critical criterion
Must include at least the items mentioned in the Intent statement and according to national requirements..

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required. A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or automated external defibrillator *(AED) within 3 minutes of any patient collapsing.*

Linked criterion:
30.2.1.2

10.2.1.5 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

10.2.1.6 Each patient has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess whether responses are effective by interviewing patients and reviewing patient complaints.

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criterion:
29.2.1.2

10.2.1.7 Electricity and water is available in accordance with the policies of

the organisation.

Ward/unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

10.2.1.8 There is a dedicated area for preparing infant feeds.

Where there is no dedicated milk kitchen, there is a designated area for preparing infant feeds.

Where feeds are prepared for a 24 hour period, suitable refrigeration and feed warming methods are available.

Protective clothing is available and the personnel maintain good infection control practices.

This criterion cannot be marked NA just because the hospital is considered a "Baby Friendly" facility.

10.3 Clinical Practice Guidelines

10.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits.
This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

10.3.1 Criteria

10.3.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

Guidelines/protocols "relevant to the patients and services" are assessed in each department according to the disease profiles of the patients admitted.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.
In the absence of guidelines this criterion will be scored NC.

Linked criterion:
1.3.2.2

10.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criterion:
8.2.1.4

10.3.1.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

10.4 Assessment of Patients

10.4.1 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters a ward, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations.

These findings are used throughout the care process to evaluate patient progress and provide information regarding the need for re-assessment. It is essential that assessments are well documented and can be easily retrieved from the patient's record.

The health organisation determines the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

10.4.1 Criteria

10.4.1.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care

Root criterion

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy. Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

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

Linked criteria:
1.3.2.1
10.1.2.2, 10.4.2.1, 10.4.3.1

10.4.1.2 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of notes made in the patient record by the doctor, or relevant clinical personnel other than nurses will affect the outcome of the audit process. The signature and designation of the individual making entries into the patients' records must be identifiable.*

Linked criterion:
10.1.1.2

10.4.1.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline.

The absence of medical notes or notes by relevant clinical personnel, other than nurses, in the patient record will affect the outcome of the audit process.

Refer to criterion 10.4.1.1

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

10.4.1.4 Policies and procedures ensure that assessments are performed within appropriate time frames and that they are adequately documented in the patients' records.

Time frames for the assessment of patients need to be established for each discipline, e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to

perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

10.4.2 Each patient has an initial assessment that complies with current policies, procedures and guidelines.

Standard Intent

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process is modified in accordance with local custom. The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge is initiated during the initial assessment process.

When the medical assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

10.4.2 Criteria

10.4.2.1 Each patient admitted has an initial assessment that meets organisational policy.

Root criterion.

Documented evidence in the form of a detailed policy and procedure or guideline is provided. To ensure Coordination of patient care, all members of the team should be included in the formulation of this policy framework, especially doctors and nurses.

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

Linked criteria:
10.4.1.1, 10.4.3.1

10.4.2.2 The initial assessment includes health history.

Compliance is measured in the relevant areas in the patient's records. This criterion will be scored PC if doctors' notes or notes by relevant clinical personnel are not available.

Compliance will be verified during the ***patient record audit.*** *This applies to all the following criteria relevant to this standard.*

10.4.2.3 The initial assessment includes physical examination.

If medical practitioner notes are not available this will be scored NC.
vital signs measurement is not considered a physical examination.

The only exceptions are where physical assessments are undertaken by nurses with special training i.e. SEs 13, 14 and 24.

10.4.2.4 The initial assessment includes functional examination, where applicable.

10.4.2.5 The initial assessment includes social and economic assessment, where applicable.

10.4.2.6 The initial assessment includes psychological assessment, where applicable.

10.4.2.7 The initial assessment includes cultural assessment, where applicable.

10.4.2.8 The initial assessment results in an initial diagnosis.

10.4.2.9 The initial assessment results in the identification of the patient's medical, nursing or other health needs.

Linked criterion:
7.2.5.2

10.4.3 Health professionals responsible for patient care collaborate to analyse and integrate assessment information.

Standard Intent

A patient benefits most when the personnel responsible for the patient work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established, and care decisions are made.

10.4.3 Criteria

10.4.3.1 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

There should be evidence that all clinical professionals dealing with the patient have contributed to the patient's record.

*Compliance with the requirements of this and the following criteria will be verified during the **patient record audit.** If notes by a relevant clinical professional are not found, the criterion will be scored PC.*

Linked criteria:
10.4.1.1, 10.4.2.1

10.4.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

10.4.3.3 Patient needs are prioritised on the basis of assessment results.

10.4.3.4 The patient and/or the family participate in the decisions regarding the priority needs to be met.

*Compliance will be verified during **patient interviews and/or** the **patient record audits**.*

10.5 Patient Care

10.5.1 The care provided to each patient is planned and written in the patient's record.

Standard Intent

A single, integrated plan is preferable to a separate care plan recorded by each health professional.

Collaborative care and treatment team meetings or similar patient discussions are recorded.

Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.

The organisation decides:

- which orders must be written rather than verbal
- who is permitted to write orders
- where orders are to be located in the patient record.

The method used must respect the confidentiality of patient care information.

10.5.1 Criteria

10.5.1.1 The planned care is provided and noted in the patient's record.

Root criterion.

*Compliance will be verified during the **patient record audit**.*
Linked criterion:
10.1.2.3

10.5.1.2 All procedures and diagnostic tests ordered and performed are written into the patient's record.

The term "written" here implies documented evidence. Such evidence may include nurses' and doctors' notes, as well as printed reports, which are filed in the patient record.

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

10.5.1.3 The results of procedures and diagnostic tests performed are available in the patient's record.

This criterion will be scored PC if the results are not initialled by the doctor, the treatment plan does not indicate action taken, or the nursing notes do not indicate that the doctor was informed.

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

10.5.1.4 Re-assessments are documented in the patient's record.

10.5.1.5 The patient's plan of care is modified when the patient's needs change.

10.5.2 Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

Standard Intent

Some patients are considered "high-risk" because of their age, condition or the critical nature of their needs. Children and the elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Policies and procedures are important. They help the personnel understand these patients and services, and respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training staff in their implementation.

The special facilities and safety measures required by children need to be specified.

It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required for the care team to work effectively
- special consent considerations
- monitoring requirements
- special qualifications or skills of the personnel involved in the care process
- the resuscitation equipment available and how to use it, including equipment for children.

Clinical guidelines should be incorporated in the process because there are several criteria requiring guidelines to be used. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high-risk patients and procedures, e.g.:

a) the care of emergency patients
b) the handling, use and administration of blood and blood products
c) the management of contaminated blood supplies (expired, opened or damaged container)
d) the care of patients on life support or those who are comatose
e) the care of patients with communicable diseases
f) the care of immuno-suppressed patients
g) the care of patients on dialysis
h) the use of restraint and the care of patients in restraint
i) the care of frail, dependent, elderly patients
j) the care of young, dependent children
k) the security of newborn babies
l) the care of adolescents.

10.5.2 Criteria

10.5.2.1 Policies and procedures for identified high-risk patients and procedures which include at least items a) to l) in the intent statement above are implemented.

The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training the personnel to implement them correctly.

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

Linked criteria:
1.3.2.1
7.2.5.1
9.2.1.8

10.5.2.2 The personnel are trained and use the policies and procedures to guide care.

*Where policies and procedures refer to patient care the same rule as 10.4.2.1 is applied, i.e. compliance will be measured against the relevant areas in the patients' records during the **record audit process.***

By implication, if the policies are implemented, the personnel can be considered to have been trained and this criterion will be scored accordingly. This "training" could take the form of formal in-service training, introduction at orientation to policies, discussions at departmental meetings, case studies, etc.

10.5.3 Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Standard Intent

This section deal with the process of obtaining informed consent from patient and does NOT refer to providing health education in general, which is dealt with in Standard 10.8.

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent for example, consent may be given verbally, by signing a consent form. Patients and families understand who may give consent, in addition to the patient.

Designated personnel are trained to inform patients and to obtain and document patient consent, e.g. a doctor for a surgical procedure or a nurse for HIV testing. These staff members clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications
- consideration of the surgical and non-surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written informed consent. Leaders document the processes for obtaining informed consent.

The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledges full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

10.5.3 Criteria

10.5.3.1 There is a documented process for obtaining informed consent.

Root criterion

This section refers to all instances where patients give informed consent and compliance will be verified during the patient ***record audit****.*

If consent was not required for the patient records audited, this whole standard becomes NA.

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 10.5.3.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC, because the process has not been implemented.

Linked criterion:
5.6.1.1

10.5.3.2 Patients are informed about their condition and the proposed treatment.

10.5.3.3 Patients know the identity of the medical practitioner or other professional practitioner responsible for their care.

Linked criterion:
10.1.1.3

10.5.3.4 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion

Compliance will be verified during the ***patient record audit.***
If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information indicated in the relevant criteria above. This criterion and the relevant criteria above will be scored C.

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria above will receive the same score.

Linked criterion:
5.6.1.1

10.5.4 Pre- and post-operative assessments are documented.

Standard Intent

The preoperative anaesthetic assessment determines whether the patient is a good candidate for the planned surgery and may significantly influence the pre- and intra-operative management. The clinical assessment and results of investigations must be available to the doctor performing the assessment.

In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition.

Appropriate re-assessments are essential to modify and guide effective treatment.
A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report is available within a time frame needed to provide post-surgical care to the patient.

Post-operative monitoring is appropriate to the patient's condition and the procedure performed.

Results of monitoring influence intra- and post-operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

10.5.4 Criteria

10.5.4.1 The patients' initial medical assessment is documented before anaesthesia.

There is documented evidence in the form of a detailed policy or guideline indicating who may perform this assessment, i.e. the person responsible for administering the anaesthetic.

Compliance with criteria 10.5.4.1 to 5 will be verified during the ***patient record audit.***

10.5.4.2 The patient's pre-operative diagnosis is recorded before anaesthesia.

10.5.4.3 A post-operative diagnosis is documented.

10.5.4.4 The name of the surgeon, and the names of other personnel as required by law, are documented.

10.5.4.5 The patient's physiological status is monitored during the immediate post-surgery period.

10.5.5 The organisation implements processes to support the patient in managing pain.

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and re-assessment
- communicate with, and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs
- educate health service providers in pain assessment and management.

10.5.5 Criteria

10.5.5.1 The assessment process makes provision for patients in pain to be identified.

10.5.5.2 Patients in pain receive care according to pain management guidelines.

There should be evidence that all clinical professionals dealing with the patient's pain management have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment. These records will also be evaluated.

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

Linked criterion:
1.3.2.1

10.5.5.3 Patients and families are educated about pain and pain management.

Compliance will be verified during the ***patient record audit and patient interviews.***

10.5.5.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.4

10.5.6 The organisation develops processes to manage end-of-life care.

Standard Intent

Dying patients have unique needs for respectful, compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all personnel are made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the organisation includes:

a) providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) sensitively addressing issues such as autopsy and organ donation
c) involving the patient and family in all aspects of care
d) responding to the psychological, emotional, spiritual and cultural concerns of the patient and family.

10.5.6 Criteria

10.5.6.1 Policies and procedures regarding end-of-life care, at least including elements a) to d) in the intent statement, are implemented.

Evidence can be sought in ***patient records*** *and by observation of the care process.*

Another example would be the manner in which the policy on withholding resuscitation is applied.

Linked criteria:
1.3.2.1
5.4.2.1

10.5.6.2 The patient and the family/significant or guardian) are involved in care decisions.

The decision should be the patient's in terms of whom they consider the most important individual to support them at this time.

10.5.6.3 Pain and primary or secondary symptoms are managed.

10.5.6.4 Interventions address patient and family religious and cultural concerns.

10.6 Medication

10.6.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

10.6.1 Criteria

10.6.1.1 Policies and procedures that guide the safe prescribing, ordering and administration of medications are implemented.

Root criterion

These policies need to be developed by all the role-players i.e. medical practitioners, nurses and pharmacists. National regulations related to medication prescription and administration will apply.Compliance will be verified during the ***patient record audit.***

Linked criteria:
1.3.2.1
10.1.1.2
21.3.1.1

10.6.1.2 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
10.6.2.3
21.3.1.1

10.6.1.3 Only those permitted by the organisation and by relevant laws and regulations prescribe medication.

Compliance will be verified during the ***patient record audit.***
Linked criterion:
10.1.1.2

10.6.1.4 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the patient's medical practitioner and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over-the-counter and homeopathic medicines.

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

Linked criterion:
21.3.1.1

10.6.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, medical practitioner, nurse, and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed~~,~~ and to evaluate the patient for adverse effects.

The organisation follows nationalrequirements for the reporting of adverse effects.

Medical practitioners, nurses, and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and personnel training are used to prevent errors in the future. The pharmacy participates in such personnel training.

10.6.2 Criteria

10.6.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:
10.1.1.2

10.6.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

10.6.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
10.6.1.2
21.3.1.1

10.6.2.4 Health professionals monitor medication effects on patients collaboratively.

***Patient record audits** should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the medical practitioner.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional Information may be required. For example, plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

10.6.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

*An **adverse drug reaction** (**ADR**) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.*

*Compliance is verified during the **patient record audit.***
Documentation showing that the reaction was reported to the medical practitioner and the pharmacist will be sought.

Linked criteria:
7.1.1.7
10.13.1.2
21.6.1.1, 21.9.1.2

10.6.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
10.13.1.2
21.6.1.1, 21.9.1.2

10.6.2.7 The medications prescribed for and administered to each patient are recorded.

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

10.6.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

10.6.3 Criteria

10.6.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerators, etc) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant personnel only.

An unlocked refrigerator in an unlocked room will be scored NC.

10.6.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

The laws and regulations or organisational policy will determine the nature of these medications.

Linked criterion:
21.5.1.11

10.6.3.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion

Compliance needs to be measured against the medicine control regulations.
Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

10.6.3.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion
National regulations will apply, but must include at least the following:

- *name of ward and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

10.6.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

10.6.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

10.6.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication.

Linked criterion:
21.5.1.9

10.6.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion

Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

10.6.3.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

10.7 Food and Nutrition Therapy

10.7.1 Food and nutrition therapy appropriate for the patient and consistent with his or her clinical care is regularly available.

Standard Intent

A qualified caregiver orders appropriate food or other nutrients. The patient participates in planning and selecting foods and the patient's family may, when appropriate, participate in providing food. They are educated as to which foods are contraindicated, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status. The nutritional status of the patients is monitored.

10.7.1 Criteria

10.7.1.1 Food, appropriate to the patient, is regularly available.

Compliance is verified during interviews with personnel and patients, especially regarding times of meals and the availability of special diets.
Menus and meal times will be checked.

Linked criterion:
26.4.1.3

10.7.1.2 An order for food, based on the patients' nutritional status and needs, is recorded in the patient's file.

*Compliance will be verified during the **patient record audit**, especially as it relates to the patient's assessment, the care plan and the identification of special dietary requirements. Prescribed diets are ordered and delivered to the patient.*

10.7.1.3 When families provide food, they are educated about the patient's diet limitations.

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

Linked criteria:
10.8.1.3

10.7.1.4 Patients assessed as being at nutrition risk receive nutrition therapy.

Patients could include malnourished children, patients unable to take normal meals for whatever reason, e.g. inability to swallow, specific disease processes. This could include the provision of nutritional supplements or the provision of full parenteral nutrition.

*This criterion and those that follow apply only to nutrition therapy and do not include special diets. Compliance of all these criteria will be verified during the **patient record audit.***

10.7.1.5 A collaborative process is used to plan, deliver and monitor nutrition therapy.

*This should include the involvement of a dietician if available. Compliance will be verified during the **patient record audit.***

Linked criteria:
1.3.2.1
21.3.1.1

10.7.1.6 Nutrition therapy provided, either oral or intravenous, is written in the patient's record.

10.7.1.7 Response to nutrition therapy is monitored and recorded.

This may take the form of weight/mass checks, laboratory tests for protein and/or lipid levels etc.

10.8 Patient and Family Education

10.8.1 Education supports patient and family participation in care decisions and care processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Personnel collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care, and continue care at home.Variables like educational literacy, beliefs and limitations are taken into account. Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record. Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administration, they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.

Community organisations that support health promotion and disease prevention education are identified and, when possible, ongoing relationships are established.

Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.

10.8.1 Criteria

10.8.1.1 Patients and families indicate that they have been informed about their diagnosis.

10.8.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
5.3.1.2

10.8.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine

and food interaction, diet and food interactions, defaulting on medication use, etc.

Linked criterion:
10.7.1.3

10.8.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

10.9 Continuity of Care

10.9.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and Coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providers may be involved in providing care. Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

10.9.1 Criteria

10.9.1.1 Policies and procedures that guide the movement of patients within the organisation are implemented.

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

10.9.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

10.9.1.3 Continuity and Coordination are evident throughout all phases of patient care.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

10.9.1.4 The record of the patient accompanies the patient when

transferred within the organisation.

10.9.2 There is a process known to personnel to appropriately refer patients for specialised consultation/investigations at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialized treatment that the referring organisation may be unable to provide. The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

10.9.2 Criteria

10.9.2.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
1.2.5.4

10.9.2.2 A copy of the referral note is available in the patient record.

10.9.2.3 Follow-up care based on the findings of investigations/consultations performed outside the organisation are noted in the patient record.

10.9.3 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation at another health facility and/or treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the

patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

10.9.3 Criteria

10.9.3.1 There is a documented process for transferring patients to other organisations.

Linked criteria:
1.2.5.4
10.9.3.6

10.9.3.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

10.9.3.3 The process for transferring the patient considers transportation needs.

10.9.3.4 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

10.9.3.5 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

10.9.3.6 A copy of the transfer summary is available in the patient record.

Critical criterion
Compliance for this criterion and the following will be verified during the patient record audit.

Linked criterion:
10.9.3.1

10.9.3.7 The health organisation agreeing to receive the patient, is noted in the patient's record.

10.9.4 There is an organised process to appropriately discharge patients.

Standard Intent

The organisation begins to plan for the patients' continuing needs as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents to ensure

continuity of care and facilitate correct management at subsequent visits. Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

The summary contains at least

a) the reason for admission
b) the diagnosis of main and significant illnesses
c) the results of investigations that will influence further management
d) all procedures performed
e) the patient's condition at discharge
f) discharge medications and
g) follow-up arrangements.

10.9.4 Criteria

10.9.4.1 There is a documented process to appropriately discharge patients.

Root criterion

Linked criteria:
1.2.5.4, 1.3.2.1

10.9.4.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

Compliance for this criterion and the following will be verified through ***patient record audits***

10.9.4.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow-up instructions may be provided to the patient by the doctor or by the nurse, following instructions from the doctor.

The instructions should include medications, wound care, possible complications, return for follow-up care, when and where to obtain urgent care, etc.

10.9.4.4 A discharge summary, which includes at least items a) to g) in the intent statement, is written, by the medical practitioner when each patient is discharged.

This criterion and the next apply to the discharge summary completed by the medical practitioner and not to the nurses' discharge note. Where a discharge summary has only been partially completed i.e. does not include all items a) to g) it will be scored PC. A nurse's discharge note is not acceptable and is scored NC.

10.9.4.5 Each record contains a copy of the discharge summary.

10.10 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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/co-ordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) patient assessment
b) surgical procedures carried out
c) the use of antibiotics and other medications and medication errors
   the use of anaesthesia
d) the use of blood and blood products
e) patient and family expectations and satisfaction.

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.

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

Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

10.10.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*

- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

10.10.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies, e.g. APACHE III. An indicator, in this context, is a measure used to determine improvements in clinical care over time.

Examples:
1. the number of bed sores/post-operative wound infections
3 nosocomial infection rates (barrier nursing/hand washing)
4. the percentage of partograms correctly completed
5. the caesarean section rate.

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

10.10.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.
Where the documentation (patient record) audit is a hospital-wide multidisciplinary process, that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

10.11 Patient Rights

10.11.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

10.11.1 Criteria

10.11.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against legislation, where applicable.

Implementation the policies will be evaluated during the patient record audits and patient interviews as well as by observation

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

10.11.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

10.11.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

10.12 Prevention and Control of Infection

10.12.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

10.12.1 Criteria

10.12.1.1 The department identifies the procedures and processes associated with the risk of infection~~,~~ and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in the~~ir~~ department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:

9.2.1.1

10.12.1.2 Infection control processes include prevention of the spread of respiratory tract infections.

10.12.1.3 Infection control processes include prevention of the spread of urinary tract infections.

10.12.1.4 Infection control processes include prevention of the spread of infection through intravascular invasive devices.

10.12.1.5 Infection control processes include prevention of the spread of infection through surgical wounds.

10.13 Risk Management

10.13.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

10.13.1 Criteria

10.13.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial, and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

10.13.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
10.6.2.5 and 6

10.13.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

10.13.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

10.13.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:7.7.1.1

SE 11 MEDICAL CARE

OVERVIEW OF MEDICAL CARE STANDARDS

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and co-ordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, laws and regulations, an individual's particular skills, knowledge and experience, and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medication, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Continuity of Care
From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation.

Processes for continuity and Coordination of care among physicians, nurses and other health service providersmust be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure Coordination of care.

Standards

11.1 Coordination of Patient Care

11.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

11.1.1 Criteria

11.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers, i.e. doctors and nurses.

Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists. It is important to assess the availability of doctors, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

11.1.1.2 The individuals responsible for patient care are qualified.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels, bed occupancy levels, etc.

The level of qualifications required would be dependent on the category of the relevant hospital. For example, a qualified general registered nurse with supervisory or management experience could be suitable as a ward manager) in a l district l hospital, while a referral level hospital would need a registered nurse with advanced nursing as well as management qualifications.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
11.4.1.2, 11.6.1.1, 11.6.2.1

11.1.1.3 The individuals responsible for patient care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times.
Patient interviews *will reveal whether staff members introduced themselves to patients.*

Linked criterion:
11.5.3.3

11.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate. The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

11.1.2 Criteria

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

Root criterion

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 relevant criteria in this document.*

Linked criterion:
1.3.2.4

11.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (doctors, nurses, professions allied to medicine, social workers, etc) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record.

Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes

made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

11.1.2.3 Information exchanged includes summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criterion:
11.5.1.1

11.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

11.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.

Methods of verifying signatures and designations could include:
- *names and designations printed below signatures*
- *stamps indicating names and designations and/or and*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

11.1.2.6 The date of each patient record entry can be identified.

*Records must follow a chronological order to allow for a logical flow of information. Compliance will be verified during the **patient record audit.***

11.1.2.7 The time of each patient record entry can be identified.

Patient records include time of arrival at the facility and each time that the patient is assessed by a health professional.

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

11.2 Facilities and Equipment

11.2.1 Adequate resources are available for the provision of safe care to patients in the ward.

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate toilet and bathing facilities for the number of patients in the ward, as determined by national legislation.

There is adequate lighting and ventilation.
Nurse call systems are available at bedsides and in bathrooms and toilets and are connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily. Each ward is provided with a socket outlet that is connected to the emergency power supply.

A resuscitation trolley is available at the point of need within 1 minute. In addition, there is access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any patient collapsing. Resuscitation equipment includes at least:

- a defibrillator with adult paddles / pads (and infant paddles / pads where applicable)
- an ECG monitor
- a CPR board (if required)
- suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- a bag-mask manual ventilator
- a range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable

- an introducer /stylet for endotracheal intubation
- a syringe to inflate the ETT cuff
- oropharyngeal tubes
- equipment to perform an emergency cricothyroidotomy – (needle and surgical)
- appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable) and
- plasma expanders.

11.2.1 Criteria

11.2.1.1 Patient and staff accommodation and equipment in the service is adequate to meet patient care needs.

Root criterion.
There should be adequate office space for personnel; clean, hygienic sluice rooms, treatment and dressing rooms; demonstration rooms, adequate, tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients, as well as the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6
29.2.1.1

11.2.1.2 Oxygen and vacuum supplies meet the needs of patients for care.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. There must also be enough functional flow-meters.

Any evidence of infection control deficiencies, e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9 (Prevention and Control of Infections).

Linked criteria:
29.2.2.1, 29.2.3.2

11.2.1.3 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture.

Linked criterion:
31.2.1.5

11.2.1.4 Resuscitation equipment is available in accordance with the policies of the organisation.

Critical criterion

Must include at least the items mentioned in the Intent statement and according to national requirements.

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or AED within 3 minutes of any patient collapsing.

Linked criterion:
30.2.1.2

11.2.1.5 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

11.2.1.6 Each patient has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess whether responses are effective by interviewing patients/guardian and patient complaints.

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criterion:
29.2.1.2

11.2.1.7 Electricity and water is available in accordance with the policies of the organisation.

Ward/unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

11.3 Clinical Practice Guidelines

11.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the

literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits.

This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

11.3.1 Criteria

11.3.1.1 Clinical practice guidelines relevant to the patients and services of the organisation are available to guide patient care processes.

Guidelines/protocols relevant to the patients and services are assessed in each department according to the disease profiles of the patients admitted.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

In the absence of guidelines, this criterion will be scored NC.

Linked criterion:
1.3.2.2

11.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criterion:
8.2.1.4

11.3.1.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

11.4 Assessment of Patients

11.4.1 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters a ward, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations.

These findings are used throughout the care process to evaluate patient progress and understand the need for reassessment. It is essential that assessments are documented well and can be easily retrieved from the patient's record.

The health organisation determines the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

11.4.1 Criteria

11.4.1.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care.

Root criterion

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy. Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

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

Linked criteria:
1.3.2.1
11.1.2.2, 11.4.2.1, 11.4.3.1

11.4.1.2 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of medical notes made in the patient record by the doctor, nurses, or relevant clinical personnel will affect the outcome of the audit process. The signature and*

designation of the individual making entries into the patients' records must be identifiable.

Linked criterion:
11.1.1.2

11.4.1.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline.

The absence of medical notes by relevant clinical personnel, in the patient record will affect the outcome of the audit process.
Refer to criterion 11.4.1.1

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

11.4.1.4 Policies and procedures ensure that assessments are performed within appropriate time frames and that they are adequately documented in the patients' records.

Time frames for the assessment of patients need to be established for each discipline, e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

11.4.2 Each patient has an initial assessment that complies with current policies, procedures and guidelines.

Standard Intent

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process is modified in accordance with national guidelines and protocols. The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge is initiated during the initial assessment process.

When the medical assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

11.4.2 Criteria

11.4.2.1 Each patient admitted has an initial assessment that meets organisational policy.

Root criterion.

Documented evidence in the form of a detailed policy and procedure or guideline is provided. To ensure Coordination of patient care, all members of the team should be included in the formulation of this policy framework, especially doctors and nurses.

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

Linked criteria:
11.4.1.1, 11.4.3.1

11.4.2.2 The initial assessment includes health history.

Compliance is measured in the relevant areas in the patient's records. This criterion will be scored PC if doctors' notes or notes by relevant clinical personnel are not available.

Compliance will be verified during the ***patient record audit.*** *This applies to all the following criteria relevant to this standard.*

11.4.2.3 The initial assessment includes physical examination.

If medical practitioner notes are not available this will be scored NC.
Vital sign measurement only is not considered a physical examination.

The only exceptions are where physical assessments are undertaken by nurses with special training i.e. SEs 13, 14 and 24.

11.4.2.4 The initial assessment includes functional examination, where applicable.

11.4.2.5 The initial assessment includes social and economic assessment, where applicable.

11.4.2.6 The initial assessment includes psychological assessment, where applicable.

11.4.2.7 The initial assessment includes cultural assessment, where applicable

11.4.2.8 The initial assessment results in an initial diagnosis.

11.4.2.9 The initial assessment results in the identification of the patient's medical, nursing or other health needs.

Linked criterion:
7.2.5.2

11.4.3 Health professionals responsible for patient care collaborate to analyse and integrate assessment information.

Standard Intent

A patient benefits most when the personnel responsible for the patient work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established, and care decisions are made.

11.4.3 Criteria

11.4.3.1 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

There should be evidence that all clinical professionals dealing with the patient have contributed to the patient's record.

Compliance with the requirements of this and the following criteria will be verified during the ***patient record audit.*** *If notes by a relevant clinical professional are not found, the criterion will be scored PC.*

Linked criteria:
11.4.1.1, 11.4.2.1

11.4.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

11.4.3.3 Patient needs are prioritised on the basis of assessment results.

11.4.3.4 The patient and/or the family participate in the decisions regarding the priority needs to be met.

Compliance will be verified during **patient interviews and/or** the **patient record audits**.

11.5 Patient Care

11.5.1 The care provided to each patient is planned and written in the patient's record.

Standard Intent

A single, integrated plan is preferable to a separate care plan recorded by each health professional.

Collaborative care and treatment team meetings or similar patient discussions are recorded.

Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.

The organisation decides:

- which orders must be written rather than verbal
- who is permitted to write orders and
- where orders are to be located in the patient record.

The method used must respect the confidentiality of patient care information.

11.5.1 Criteria

11.5.1.1 The planned care is provided and noted in the patient's record.

Root criterion.

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

Linked criterion:
11.1.2.3

11.5.1.2 All procedures and diagnostic tests ordered and performed are written into the patient's record.

The term "written" here implies documented evidence. Such evidence may include nurses' and doctors' notes, as well as printed reports, which are filed in the patient record.

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

11.5.1.3 The results of procedures and diagnostic tests performed are available in the patient's record.

This criterion will be scored PC if the results are not initialled by the doctor, the treatment plan does not indicate action taken, or the nursing notes do not indicate that the doctor was informed.

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

11.5.1.4 Re-assessments are documented in the patient's record.

11.5.1.5 The patient's plan of care is modified when the patient's needs change.

11.5.2 Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

Standard Intent

Some patients are considered "high-risk" because of their age, condition or the critical nature of their needs. Children and the elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Policies and procedures are important. They help the personnel understand these patients and services, and respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training staff in their implementation.

Special facilities and safety measures required by children need to be specified.
It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required for the care team to work effectively
- special consent considerations
- monitoring requirements
- special qualifications or skills of the personnel involved in the care process
- the resuscitation equipment available and how to use it, including equipment for children.

Clinical guidelines should be incorporated in the process because there are several criteria requiring guidelines to be used. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high-risk patients and procedures, e.g.:

a) the care of emergency patients
b) the handling, use and administration of blood and blood products
c) the management of contaminated blood supplies (expired, opened or damaged container)
d) the care of patients on life support or those who are comatose
e) the care of patients with communicable diseases
f) the care of immuno-suppressed patients
g) the care of patients on dialysis
h) the use of restraint and the care of patients in restraint
i) the care of frail, dependent, elderly patients
j) the care of young, dependent children
k) the care of adolescents.

11.5.2 Criteria

11.5.2.1 Policies and procedures for identified high-risk patients and procedures, which include at least items a) to k) in the intent statement, are implemented.

The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training the personnel to implement them correctly.
Compliance will be verified during the patient ***record audit****.*

Linked criteria:
1.3.2.1
7.2.5.1
9.2.1.8

11.5.2.2 The personnel are trained and use the policies and procedures to guide care.

Where policies and procedures refer to patient care the same rule as 11.4.2.1 is applied, i.e. compliance will be measured against the relevant areas in the patients' records during the ***record audit process.***

By implication, if the policies are implemented, the personnel can be considered to have been trained and this criterion will be scored accordingly. This "training" could take the form of formal in-service training, introduction at orientation to policies, discussions at departmental meetings, case studies, etc.

11.5.3 Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Standard Intent

This section deal with the process of obtaining informed consent from patient and does NOT refer to providing health education in general, which is dealt with in Standard 11.8.

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent. For example, consent may be given verbally, by signing a consent form, or through some other mechanism. Patients and families understand who may give consent~~,~~ in addition to the patient.

Designated personnel are trained to inform patients and to obtain and document patient consent. These staff members clearly explain any proposed treatments or procedures to the patient and when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications
- consideration of the surgical and non-surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written informed consent.

Leaders document the processes for obtaining informed consent.

The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledged full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

11.5.3 Criteria

11.5.3.1 There is a documented process for obtaining informed consent.

Root criterion

*This section refers to all instances where patients give informed consent and compliance will be verified during the patient **record audit**.*

If consent was not required for the patient records audited, this whole standard becomes NA.

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 11.5.3.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC because the process has not been implemented.

Linked criterion:
5.6.1.1

11.5.3.2 Patients are informed about their condition and the proposed treatment.

11.5.3.3 Patients know the identity of the medical practitioner or other professional practitioner responsible for their care.

Linked criterion:
11.1.1.3

11.5.3.4 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion

*Compliance will be verified during the **patient record audit.***
If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information indicated in the relevant criteria above. This criterion and the relevant criteria above will be scored C.

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria

above will receive the same score.

Linked criterion:
5.6.1.1

11.5.4 Pre- and post-operative assessments are documented.

Standard Intent

In terms of medical care, invasive procedures related to the medical condition, such as cardiac catheterization, are considered in this section of the standards.

The preoperative anaesthetic assessment determines whether the patient is a good candidate for the planned surgery and may significantly influence the pre- and intra-operative management. The clinical assessment and results of investigations must be available to the doctor performing the assessment.

In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition.

Appropriate re-assessments are essential to modify and guide effective treatment.

A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report is available within a time frame needed to provide post-surgical care to the patient.

Post-operative monitoring is appropriate to the patient's condition and the procedure performed.

Results of monitoring influence intra- and post-operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

11.5.4 Criteria

11.5.4.1 The patients' initial medical assessment is documented before anaesthesia.

There is documented evidence in the form of a detailed policy or guideline indicating who may perform this assessment, i.e. the person responsible for administering the anaesthetic.

Compliance with criteria 11.5.4.1 to 5 will be verified during the ***patient record audit.***

11.5.4.2 Patients have a preoperative diagnosis recorded before anaesthesia.

11.5.4.3 A post-operative diagnosis is documented.

11.5.4.4 The name of the surgeon, and the names of other personnel as required by law, are documented.

11.5.4.5 The patient's physiological status is monitored during the immediate post-surgery period.

11.5.5 The organisation implements processes to support the patient in managing pain.

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and reassessment
- communicate with, and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs
- educate health service providersin pain assessment and management.

11.5.5 Criteria

11.5.5.1 The assessment process makes provision for patients in pain to be identified.

11.5.5.2 Patients in pain receive care according to pain management guidelines.

There should be evidence that all clinical professionals dealing with the patient's pain management have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment. These records will also be evaluated.

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

Linked criterion:
1.3.2.1

11.5.5.3 Patients and families are educated about pain and pain management.

Compliance will be verified during the ***patient record audit and patient interviews.***

11.5.5.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.4

11.5.6 The organisation develops processes to manage end-of-life care.

Standard Intent

Dying patients have unique needs for respectful, compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all personnel are made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the organisation includes:

a) providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) sensitively addressing issues such as autopsy and organ donation
c) involving the patient and family in all aspects of care
d) responding to the psychological, emotional, spiritual and cultural concerns of the patient and family.

11.5.6 Criteria

11.5.6.1 Policies and procedures regarding end-of-life care at least including elements a) to d) in the intent statement are implemented.

*Evidence can be sought in **patient records** and by observation of the care process. Another example would be the manner in which the policy on withholding resuscitation is applied.*

Linked criteria:
1.3.2.1
5.4.2.1

11.5.6.2 The patient and the family/guardian are involved in care decisions.

The decision should be the patient's in terms of whom they consider the most important individual to support them at this time.

11.5.6.3 Pain and primary or secondary symptoms are managed.

11.5.6.4 Interventions address patient and family religious and cultural concerns.

11.6 Medication

11.6.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

11.6.1 Criteria

11.6.1.1 Policies and procedures that guide the safe prescribing, ordering and administration of medications are implemented.

Root criterion

These policies need to be developed by all the role-players, i.e. medical practitioners, nurses and pharmacists.

national regulations related to medication prescription and administration will apply. Compliance will be verified during the ***patient record audit.***

Linked criteria:
1.3.2.1
11.1.1.2
21.1.2.1, 21.3.1.1

11.6.1.2 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
11.6.2.3
21.3.1.1

11.6.1.3 Only those permitted by the organisation and by relevant law and regulation prescribe medication.

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

Linked criterion:
11.1.1.2

11.6.1.4 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the patient's medical practitioner and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over-the-counter and homeopathic medicines.

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

Linked criterion:
21.3.1.1

11.6.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, medical practitioner, nurse and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed~~,~~ and to evaluate the patient for adverse effects.

The organisation follows national requirements for the reporting of adverse effects. Doctors, nurses, and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

11.6.2 Criteria

11.6.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:
11.1.1.2

11.6.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

11.6.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
11.6.1.2
21.3.1.1

11.6.2.4 Health professionals monitor medication effects on patients collaboratively.

***Patient record audits** should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the medical practitioner.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional Information may be required. For example, plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

11.6.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

*An **adverse drug reaction** (**ADR**) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.*

*Compliance is verified during the **patient record audit.***
Documentation showing that the reaction was reported to the medical practitioner and the pharmacist will be sought.

Linked criteria:
7.1.1.7
11.13.1.2
21.6.1.1, 21.9.1.2

11.6.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
11.13.1.2
21.6.1.1, 21.9.1.2

11.6.2.7 The medications prescribed for and administered to each patient are recorded.

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

11.6.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

11.6.3 Criteria

11.6.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerators, etc) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant personnel only.

An unlocked refrigerator in an unlocked room will be scored NC.

11.6.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

The laws and regulations or organisational policy will determine the nature of these medications.

Linked criterion:
21.5.1.11

11.6.3.3 Medications identified for special control (by law or organisational

policy) are accurately accounted for.

Critical criterion

Compliance needs to be measured against the medicine control regulations. Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

11.6.3.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion

National regulations will apply, but must include at least the following

- *name of ward and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number and*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

11.6.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

Linked criterion:
21.5.1.7

11.6.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

11.6.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication

Linked criterion:
21.5.1.9

11.6.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion

Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.
Linked criterion:
21.5.1.8

11.6.3.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

11.7 Food and Nutrition Therapy

11.7.1 Food and nutrition therapy appropriate for the patient and consistent with his or her clinical care is regularly available.

Standard Intent

A qualified caregiver orders appropriate food or other nutrients. The patient participates in planning and selecting foods, and the patient's family may, when appropriate, participate in providing food. They are educated as to which foods are contraindicated, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status.

The nutritional status of the patients is monitored.

11.7.1 Criteria

11.7.1.1 Food, appropriate to the patient, is regularly available.

Compliance is verified during interviews with personnel and patients, especially regarding times of meals and the availability of special diets.
Menus and meal times will be checked.

Linked criterion:
26.4.1.3

11.7.1.2 An order for food, based on the patients' nutritional status and needs, is recorded in the patient's file.

*Compliance will be verified during the **patient record audit**, especially as it relates to the patient's assessment, the care plan and the identification of special dietary requirements. Prescribed diets are ordered and delivered to the patient.*

11.7.1.3 When families provide food, they are educated about the patient's diet limitations.

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

Linked criteria:
11.8.1.3

11.7.1.4 Patients assessed as being at nutrition risk receive nutrition therapy.

Patients could include malnourished children, patients unable to take normal meals for whatever reason, e.g. inability to swallow, specific disease processes. This could include the provision of nutritional supplements or the provision of full parenteral nutrition.

This criterion and those that follow apply only to nutrition therapy and do not include special diets.

*Compliance of all these criteria will be verified during the **patient record audit.***

11.7.1.5 A collaborative process is used to plan, deliver and monitor nutrition therapy.

*This should include the involvement of a dietician if available. Compliance will be verified during the **patient record audit.***

Linked criteria:
1.3.2.1
21.3.1.1

11.7.1.6 Nutrition therapy provided, either oral or intravenous, is written in the patient's record.

11.7.1.7 Response to nutrition therapy is monitored and recorded.

This may take the form of weight/mass checks, laboratory tests for protein and/or lipid levels etc.

11.8 Patient and Family Education

11.8.1 Each supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care, and continue care at home. Variables like educational literacy, beliefs and limitations are taken into account.

Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administration, they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.

Community organisations that support health promotion and disease prevention education are identified and, when possible, on-going relationships are established.

*Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.*

11.8.1 Criteria

11.8.1.1 Patients and families indicate that they have been informed about their diagnosis.

11.8.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
5.3.1.2

11.8.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use, etc.

Linked criterion:
11.7.1.3

11.8.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

11.9 Continuity of Care

11.9.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and Coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providersmay be involved in providing care. Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

11.9.1 Criteria

11.9.1.1 Policies and procedures that guide the movement of patients within the organisation are implemented.

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

11.9.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

11.9.1.3 Continuity and Coordination are evident throughout all phases of patient care.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

11.9.1.4 The record of the patient accompanies the patient when transferred within the organisation.

11.9.2 There is a process known to personnel to appropriately refer patients for specialised consultation/investigations at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialized treatment that the referring organisation may be unable to provide. The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

11.9.2 Criteria

11.9.2.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
1.2.5.4

11.9.2.2 A copy of the referral note is available in the patient record.

11.9.2.3 Follow-up care based on the findings of investigations/consultations performed outside the organisation is noted in the patient record.

11.9.3 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation at another health facility and/or treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual

accompanying the patient must be appropriate.

11.9.3 Criteria

11.9.3.1 There is a documented process for transferring patients to other organisations.

Linked criteria:
1.2.5.4
11.9.3.6

11.9.3.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

11.9.3.3 The process for transferring the patient considers transportation needs.

11.9.3.4 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

11.9.3.5 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

11.9.3.6 A copy of the transfer summary is available in the patient record.

Critical criterion

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
11.9.3.1

11.9.3.7 The health organisation agreeing to receive the patient is noted in the patient's record.

11.9.4 *There is an organised process to appropriately discharge patients.*

Standard Intent

The organisation begins to plan for the patients' continuing needs as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the organisation may include when to resume daily

activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

The summary contains at least:

a) the reason for admission
b) the diagnosis of main and significant illnesses
c) the results of investigations that will influence further management
d) all procedures performed
e) the patient's condition at discharge
f) discharge medications
g) follow-up arrangements.

11.9.4 Criteria

11.9.4.1 There is a documented process to appropriately discharge patients.

Root criterion
Linked criteria:
1.2.5.4, 1.3.2.1

11.9.4.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

Compliance for this criterion and the following will be verified through ***patient record audits***

11.9.4.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow-up instructions may be provided to the patient by the doctor or by the nurse, following instructions from the doctor.

The instructions should include medications, wound care, possible complications, return for follow-up care, when and where to obtain urgent care, etc.

11.9.4.4 A discharge summary, which includes at least items a) to g) in the intent statement, is written by the medical practitioner when each patient is discharged.

This criterion and the next apply to the discharge summary completed by the medical practitioner and not to the nurses' discharge note. Where a discharge summary has only been partially completed i.e. does not include all items a) to g) it will be scored PC. A nurse's discharge note is not acceptable and is scored NC.

11.9.4.5 Each record contains a copy of the discharge summary

11.10 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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/co-ordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) patient assessment
b) procedures carried out
c) the use of antibiotics and other medications and medication errors
d) the use of blood and blood products
e) patient and family expectations and satisfaction.

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.

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

Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

11.10.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit*

- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

11.10.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies, e.g. APACHE III. An indicator, in this context, is a measure used to determine improvements in clinical care over time.

Examples:
1. *the number of bed sores/post-operative wound infections*
2. *nosocomial infection rates (barrier nursing/hand washing*
3. *the percentage of partograms correctly completed; and*
4. *the caesarean section rate.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

11.10.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.

Where the documentation (patient record) audit is a hospital-wide multidisciplinary process that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

11.11 Patient Rights

11.11.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

11.11.1 Criteria

11.11.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against legislation, where applicable.

Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

11.11.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

11.11.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

11.12 Prevention and Control of Infection

11.12.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

11.12.1 Criteria

11.12.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

11.12.1.2 Infection control processes include prevention of the spread of respiratory tract infections.

11.12.1.3 Infection control processes include prevention of the spread of urinary tract infections.

11.12.1.4 Infection control processes include prevention of the spread of infection through intravascular invasive devices.

11.12.1.5 Infection control processes include prevention of the spread of infection through surgical wounds.

11.13 Risk Management

11.13.1 The department/ service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

11.13.1 Criteria

11.13.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

11.13.1.2 A system for monitoring incidents, near misses, sentinel and adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation at department level, in the facility's overall system for monitoring negative incidents, near misses and adverse events will be evaluated.

Analysed data with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
11.6.2.5 and 6

11.13.1.3 Security measures are in place and are implemented to ensure the

safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

11.13.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

11.13.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 12 SURGICAL CARE

OVERVIEW OF SURGICAL CARE STANDARDS

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and co-ordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, laws and regulations, an individual's particular skills, knowledge and experience, and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medication, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Continuity of Care:
From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation.

Processes for continuity and Coordination of care among medical practitioners, nurses and other health service providersmust be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure Coordination of care.

Standards

12.1 Coordination of Patient Care

12.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

12.1.1 Criteria

12.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers, i.e. doctors and nurses.
Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists.

It is important to assess the availability of doctors, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

12.1.1.2 The individuals responsible for the patient's care are qualified.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels, bed occupancy levels, etc.

The level of qualifications required would be dependent on the category of the relevant hospital, e.g., a qualified general registered nurse with supervisory or management experience could be suitable as a ward manager) in a district l hospital, while a referral hospital would need a registered nurse with advanced nursing as well as management qualifications.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
10.4.1.2, 10.6.1.1, 10.6.2.1

12.1.1.3 The individuals responsible for the patient's care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times.
***Patient interviews** will reveal whether staff members introduced themselves to patients.*

Linked criterion:
10.5.3.3

12.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

12.1.2 Criteria

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

Root criterion
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 relevant criteria in this document.*

Linked criterion:
1.3.2.4

12.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (doctors, nurses, professions allied to medicine, social workers, etc) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record.

Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

12.1.2.3 Information exchanged includes a summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criterion:
10.5.1.1

12.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

12.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.
Methods of verifying signatures and designations could include:

- *names and designations printed below signatures*
- *stamps indicating names and designations and/or*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

12.1.2.6 The date of each patient record entry can be identified.

Records must follow a chronological order to allow for a logical flow of information. Compliance will be verified during the ***patient record audit.***

12.1.2.7 The time of each patient record entry can be identified.

Patient records include time of arrival at the facility and each time that the patient is assessed by a health professional.

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

12.2 Facilities and Equipment

12.2.1 *Adequate resources are available for the provision of safe care to patients in the ward.*

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate toilet and bathing facilities for the number of patients in the ward, as determined by national legislation.

There is adequate lighting and ventilation.

Nurse call systems are available at bedsides and in bathrooms and toilets and are connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily. Each ward is provided with a socket outlet that is connected to the emergency power supply.

A resuscitation trolley is available at the point of need within 1 minute. In addition, there is access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any patient collapsing. Resuscitation equipment includes at least:

- a defibrillator with adult paddles / pads (and infant paddles / pads where applicable)
- an ECG monitor
- a CPR board (if required)
- suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- a bag-mask manual ventilator
- a range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable

- an introducer /stylet for endotracheal intubation
- a syringe to inflate the ETT cuff
- oropharyngeal tubes
- equipment to perform an emergency cricothyroidotomy – (needle and surgical)
- appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
- plasma expanders.

12.2.1 Criteria

12.2.1.1 Patient and staff accommodation and equipment is adequate to meet patient care needs.

Root criterion

There should be adequate office space for personnel; clean, hygienic sluice rooms, treatment and dressing rooms; demonstration rooms, adequate and tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients.as well as the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6
29.2.1.1

12.2.1.2 Oxygen and vacuum supplies meet the needs of patients for care.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. There must also be enough functional flow-meters.

Any evidence of infection control deficiencies, e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9 (Prevention and Control of Infections).

Linked criteria:
29.2.2.1, 29.2.3.2

12.2.1.3 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture..

Linked criterion:
31.2.1.5

12.2.1.4 Resuscitation equipment is available in accordance with the

policies of the organisation.

Critical criterion

Must include at least the items mentioned in the intent statement and according to national requirements.

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or automated external defibrillator *(AED) within 3 minutes of any patient collapsing.*

Linked criterion:
30.2.1.2

12.2.1.5 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

12.2.1.6 Each patient has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess whether responses are effective by interviewing patients/guardian; and reviewing patient and customer complaints.

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criterion:
29.2.1.2

12.2.1.7 Electricity and water is available in accordance with the policies of the organisation.

Ward/unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

12.3 Clinical Practice Guidelines

12.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

12.3.1 Criteria

12.3.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

Guidelines/protocols "relevant to the patients and services" are assessed in each department according to the disease profiles of the patients admitted.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

In the absence of guidelines, this criterion will be scored NC.

Linked criterion:
1.3.2.2

12.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criterion:
8.2.1.4

12.3.1.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:

1.3.2.2

12.4 Assessment of Patients

12.4.1 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters a ward, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations.

These findings are used throughout the care process to evaluate patient progress and provide information regarding the need for re-assessment. It is essential that assessments are well documented and can be easily retrieved from the patient's record.

The health organisation determines the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

12.4.1 Criteria

12.4.1.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care.

Root criterion

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy. Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

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

Linked criteria:
1.3.2.1
12.1.2.2, 12.4.2.1, 12.4.3.1

12.4.1.2 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The*

absence of notes made in the patient record by the doctor or relevant clinical personnel other than nurses will affect the outcome of the audit process. The signature and designation of the individual making entries into the patients' records must be identifiable.

Linked criterion:
12.1.1.2

12.4.1.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline.

The absence of medical notes by relevant clinical personnel, in the patient record will affect the outcome of the audit process.

Refer to criterion 12.4.1.1

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

12.4.1.4 Policies and procedures ensure that assessments are performed within appropriate time frames and that they are adequately documented in the patients' records.

Time frames for the assessment of patients need to be established for each discipline, e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

12.4.2 Each patient has an initial assessment that complies with current policies, procedures and guidelines.

Standard Intent

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process is modified in accordance with national guidelines and protocols. The outcome from the patient's initial assessment results in an understanding of the patient's medical

and nursing needs so that care and treatment can begin.

Planning for discharge is initiated during the initial assessment process. When the medical assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

12.4.2 Criteria

12.4.2.1 Each patient admitted has an initial assessment that meets organisational policy.

Root criterion.

Documented evidence in the form of a detailed policy and procedure or guideline is provided. To ensure Coordination of patient care, all members of the team should be included in the formulation of this policy framework, especially doctors and nurses.

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

Linked criteria:
12.4.1.1, 12.4.3.1

12.4.2.2 The initial assessment includes health history.

Compliance is measured in the relevant areas in the patient's records. This criterion will be scored PC if doctors' notes or notes by relevant clinical personnel are not available.

Compliance will be verified during the ***patient record audit.*** *This applies to all the following criteria relevant to this standard.*

12.4.2.3 The initial assessment includes physical examination.

If medical practitioner notes are not available this will be scored NC.

Vital sign measurement only is not considered a physical examination.

The only exceptions are where physical assessments are undertaken by nurses with special training i.e. SEs 13, 14 and 24.

12.4.2.4 The initial assessment includes functional examination, where applicable.

12.4.2.5 The initial assessment includes social and economic assessment, where applicable.

12.4.2.6 The initial assessment includes psychological assessment, where applicable.

12.4.2.7 The initial assessment includes cultural assessment, where applicable.

12.4.2.8 The initial assessment results in an initial diagnosis.

12.4.2.9 The initial assessment results in the identification of the patient's medical, nursing or other health needs.

Linked criterion:
7.2.5.2

12.4.3 Health professionals responsible for patient care collaborate to analyse and integrate assessment information.

Standard Intent

A patient benefits most when the personnel responsible for the patient work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established and care decisions are made.

12.4.3 Criteria

12.4.3.1 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

There should be evidence that all clinical professionals dealing with the patient have contributed to the patient's record.

Compliance with the requirements of this and the following criteria will be verified during the ***patient record audit.*** *If notes by a relevant clinical professional are not found, the criterion will be scored PC.*

Linked criteria:
12.4.1.1, 12.4.2.1

12.4.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

12.4.3.3 Patient needs are prioritised on the basis of assessment results.

12.4.3.4 The patient and/or the family participate in the decisions regarding the priority needs to be met.

Compliance will be verified during ***patient interviews and/or*** *the* ***patient record audits****.*

12.5 Patient Care

12.5.1 The care provided to each patient is planned and written in the patient's record.

Standard Intent

A single, integrated plan is preferable to a separate care plan recorded by each health professional.

Collaborative care and treatment team meetings or similar patient discussions are recorded.

Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.

The organisation decides:

- which orders must be written rather than verbal
- who is permitted to write orders
- where orders are to be located in the patient's records.

The method used must respect the confidentiality of patient care information.

12.5.1 Criteria

12.5.1.1 The planned care is provided and noted in the patient's record.

Root criterion.

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

Linked criterion:
12.1.2.3

12.5.1.2 All procedures and diagnostic tests ordered and performed are written into the patient's record.

The term "written" here implies documented evidence. Such evidence may include nurses' and doctors' notes as well as printed reports, which are filed in the patient record.

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

12.5.1.3 The results of procedures and diagnostic tests performed are available in the patient's record.

This criterion will be scored PC if the results are not initialled by the doctor, the treatment plan does not indicate action taken, or the nursing notes do not indicate that the doctor was informed.

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

12.5.1.4 Re-assessments are documented in the patient's record.

12.5.1.5 The patient's plan of care is modified when the patient's needs change.

12.5.2 *Policies and procedures guide the care of high-risk patients and the provision of high-risk services.*

Standard Intent

Some patients are considered "high-risk" because of their age, condition or the critical nature of their needs. Children and the elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Policies and procedures are important. They help the personnel understand these patients and services, and respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training staff in their implementation.

The special facilities and safety measures required by children need to be specified. It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required for the care team to work effectively
- special consent considerations
- monitoring requirements
- special qualifications or skills of the personnel involved in the care process
- the resuscitation equipment available and how to use it, including equipment for children.

Clinical guidelines should be incorporated in the process because there are several criteria requiring guidelines to be used. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high-risk patients and procedures, e.g.:

a) the care of emergency patients
b) the handling, use and administration of blood and blood products
c) the management of contaminated blood supplies (expired, opened or damaged container)
d) the care of patients on life support or those who are comatose
e) the care of patients with communicable diseases
f) the care of immuno-suppressed patients
g) the care of patients on dialysis
h) the use of restraint and the care of patients in restraint
i) the care of frail, dependent, elderly patients
j) the care of young, dependent children
k) the care of adolescents.

12.5.2 Criteria

12.5.2.1 Policies and procedures for identified high-risk patients and procedures, which include at least items a) to k) in the intent statement above, are implemented.

The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training the personnel to implement them correctly.

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

Linked criteria:
1.3.2.1
7.2.5.1
9.2.1.8

12.5.2.2 The personnel are trained and use the policies and procedures to guide care.

*Where policies and procedures refer to patient care the same rule as 12.4.2.1 is applied, i.e. compliance will be measured against the relevant areas in the patients' records during the **record audit process.***

By implication, if the policies are implemented, the personnel can be considered to have been trained and this criterion will be scored accordingly. This "training" could take the form of formal in-service training, introduction at orientation to policies, discussions at departmental meetings, case studies, etc.

12.5.3 Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Standard Intent

This section deals with the process of obtaining informed consent from patient and does not refer to providing health education in general, which is dealt with in Standard 12.8.

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent, e.g, consent may be given verbally, by signing a consent form, or through some other mechanism. Patients and families understand who may give consent in addition to the patient.

Designated personnel are trained to inform patients and to obtain and document patient consent, e.g. a doctor for a surgical procedure or a nurse for HIV testing. These staff members clearly explain any proposed treatments or procedures to the patient, and, when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications

- consideration of the surgical and non-surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written, informed consent. Leaders document the processes for obtaining informed consent.
The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledges full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

12.5.3 Criteria

12.5.3.1 There is a documented process for obtaining informed consent.

Root criterion
This section refers to all instances where patients give informed consent and compliance will be verified during the patient ***record audit****.*

If consent was not required for the patient records audited, this whole standard becomes NA.

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 12.5.3.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC because the process has not been implemented.

Linked criterion:
5.6.1.1

12.5.3.2 Patients are informed about their condition and the proposed treatment.

12.5.3.3 Patients know the identity of the medical practitioner or other professional practitioner responsible for their care.

Linked criterion:
12.1.1.3

12.5.3.4 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion
Compliance will be verified during the ***patient record audit.***
If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information indicated in the relevant criteria above. This criterion and the relevant criteria above will be scored C.

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria above will receive the same score.

Linked criterion:
5.6.1.1

12.5.4 Pre- and post-operative assessments are documented.

Standard Intent

The preoperative anaesthetic assessment determines whether the patient is a good candidate for the planned surgery and may significantly influence the pre- and intra-operative management. The clinical assessment and results of investigations must be available to the doctor performing the assessment.

In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition.

Appropriate re-assessments are essential to modify and guide effective treatment.
A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report is available within a time frame needed to provide post-surgical care to the patient.

Post-operative monitoring is appropriate to the patient's condition and the procedure performed.

Results of monitoring influence intra- and post-operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

12.5.4 Criteria

12.5.4.1 The patients' initial medical assessment is documented before anaesthesia.

There is documented evidence in the form of a detailed policy or guideline indicating who may perform this assessment, i.e. the person responsible for administering the anaesthetic.

Compliance with criteria 12.5.4.1 to 5 will be verified during the ***patient record audit.***

12.5.4.2 The patient's pre-operative diagnosis is recorded before anaesthesia.

12.5.4.3 A post-operative diagnosis is documented.

12.5.4.4 The names of the surgeon, and the names of other personnel as required by law, are documented.

12.5.4.5 The patient's physiological status is monitored during the immediate post-surgery period.

12.5.5 *The organisation implements processes to support the patient in managing pain.*

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and re-assessmen;t
- communicate with, and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs; and
- educate health service providersin pain assessment and management.

12.5.5 Criteria

12.5.5.1 The assessment process makes provision for patients in pain to be identified.

12.5.5.2 Patients in pain receive care according to pain management guidelines.

There should be evidence that all clinical professionals dealing with the patient's pain management have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment. These records will also be evaluated.

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

Linked criterion:
1.3.2.1

12.5.5.3 Patients and families are educated about pain and pain management.

Compliance will be verified during the ***patient record audit and patient interviews.***

12.5.5.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.4

12.5.6 *The organisation develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all personnel are made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the organisation includes:

a) providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) sensitively addressing issues such as autopsy and organ donation
c) involving the patient and family in all aspects of care
d) responding to the psychological, emotional, spiritual and cultural concerns of the patient and family.

12.5.6 Criteria

12.5.6.1 Policies and procedures regarding end-of-life care, at least including elements a) to d) in the intent statement are implemented.

*Evidence can be sought in **patient records** and by observation of the care process. Another example would be the manner in which the policy on withholding resuscitation is applied.*

Linked criteria:
1.3.2.1
5.4.2.1

12.5.6.2 The patient and the family/guardian are involved in care decisions.

The decision should be the patient's in terms of whom they consider the most important individual to support them at this time.

12.5.6.3 Pain and primary or secondary symptoms are managed.

12.5.6.4 Interventions address patient and family religious and cultural concerns.

12.6 Medication

12.6.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

12.6.2 Criteria

12.6.2.1 Policies and procedures that guide the safe prescribing, ordering and administration of medications are implemented.

Root criterion

These policies need to be developed by all the role-players, i.e. medical practitioners, nurses and pharmacists.

National regulations related to medication prescription and administration will apply. Compliance will be verified during the ***patient record audit.***

Linked criteria:
1.3.2.1
12.1.1.2
21.1.2.1, 21.3.1.1

12.6.2.2 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
12.6.2.3
21.3.1.1

12.6.2.3 Only those permitted by the organisation and by relevant laws and regulations prescribe medication.

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

Linked criterion:
12.1.1.2

12.6.2.4 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the patient's medical practitioner and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over-the-counter and homeopathic medicines.

Compliance will be verified during the ***patient record audit.***
Linked criterion:
21.3.1.1

12.6.3 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, medical practitioner, nurse and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed and to evaluate the patient for adverse effects.

The organisation follows national requirements for the reporting of adverse effects. Doctors, nurses, and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

12.6.2 Criteria

12.6.3.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:
12.1.1.2

12.6.3.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

12.6.3.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments. During the ***patient record audit*** *process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
12.6.1.2
21.3.1.1

12.6.3.4 Health professionals monitor medication effects on patients collaboratively.

Patient record audits *should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the medical practitioner.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional information may be required, e.g, plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

12.6.3.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

An ***adverse drug reaction*** *(****ADR****) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.*

Compliance is verified during the ***patient record audit.***
Documentation showing that the reaction was reported to the medical practitioner and the pharmacist will be sought.

Linked criteria:
7.1.1.7
12.13.1.2

21.6.1.1, 21.9.1.2

12.6.3.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
12.13.1.2
21.6.1.1, 21.9.1.2

12.6.3.7 The medications prescribed for and administered to each patient are recorded.

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

12.6.4 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

12.6.4 Criteria

12.6.4.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerators, etc) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant personnel only.

An unlocked refrigerator in an unlocked room will be scored NC.

12.6.4.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

The laws and regulations or organisational policy will determine the nature of these medications.

Linked criterion:
21.5.1.12

12.6.4.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion

Compliance needs to be measured against the medicine control regulations.
Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

12.6.4.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion
National regulations will apply, but must include at least the following:

- *name of ward and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number and*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

12.6.4.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

Linked criterion:
21.5.1.7

12.6.4.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

12.6.4.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication.

Linked criterion:
21.5.1.9

12.6.4.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion

Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

12.6.4.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

12.7 Food and Nutrition Therapy

12.7.1 Food and nutrition therapy appropriate for the patient and consistent with his or her clinical care is regularly available.

Standard Intent

A qualified caregiver orders appropriate food or other nutrients. The patient participates in planning and selecting foods, and the patient's family may, when appropriate, participate in providing food. They are educated as to which foods are contraindicated, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status.The nutritional status of the patients is monitored.

12.7.1 Criteria

12.7.1.1 Food, appropriate to the patient, is regularly available.

Compliance is verified during interviews with personnel and patients, especially regarding times of meals and the availability of special diets.
Menus and meal times will be checked.

Linked criterion:
26.4.1.3

12.7.1.2 An order for food, based on the patients' nutritional status and needs, is recorded in the patient's file.

*Compliance will be verified during the **patient record audit**, especially as it relates to the patient's assessment, the care plan and the identification of special dietary requirements. Prescribed diets are ordered and delivered to the patient.*

12.7.1.3 When families provide food, they are educated about the patient's diet limitations.

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

Linked criteria:
12.8.1.3

12.7.1.4 Patients assessed as being at nutrition risk receive nutrition therapy.

Patients could include malnourished children, patients unable to take normal meals for whatever reason, e.g. inability to swallow, specific disease processes. This could include the provision of nutritional supplements or the provision of full parenteral nutrition.

*This criterion and those that follow apply only to nutrition therapy and do not include special diets.Compliance of all these criteria will be verified during the **patient record audit.***

12.7.1.5 A collaborative process is used to plan, deliver and monitor nutrition therapy.

*This should include the involvement of a dietician if available. Compliance will be verified during the **patient record audit.***

Linked criteria:
1.3.2.1
21.3.1.1

12.7.1.6 Nutrition therapy provided, either oral or intravenous, is written in the patient's record.

12.7.1.7 Response to nutrition therapy is monitored and recorded.

This may take the form of weight/mass checks, laboratory tests for protein and/or lipid levels, etc.

12.8 Patient and Family Education

12.8.1 Education supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible. Education is focused on the specific knowledge and skills that the patient and his or her family will need to participate and make decisions on how to continue with care continue care at home. Variables like educational literacy, beliefs and limitations are taken into account.

Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administration, they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.

Community organisations that support health promotion and disease prevention education are identified, and when possible, on-going relationships are established.

*Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.*

12.8.1 Criteria

12.8.1.1 Patients and families indicate that they have been informed about their diagnosis.

12.8.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
5.3.1.2

12.8.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use etc.

Linked criterion:
12.7.1.3

12.8.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

12.9 Continuity of Care

12.9.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and Coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments, services and many different health service providersmay be involved in providing care.

Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

12.9.1 Criteria

12.9.1.1 Policies and procedures that guide the movement of patients within the organisation are implemented.

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

12.9.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

*Compliance for this criterion and the following will be verified during the **patient record audit.***

12.9.1.3 Continuity and Coordination are evident throughout all phases of patient care.

*Compliance for this criterion and the following will be verified during the **patient record audit.***

12.9.1.4 The record of the patient accompanies the patient when transferred within the organisation.

12.9.2 There is a process known to personnel to appropriately refer patients for specialised consultation/investigations at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialized treatment that the referring organisation may be unable to provide. The organisation must clearly describe the

referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

12.9.2.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then returned to the original facility.

Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
1.2.5.4

12.9.2.2 A copy of the referral note is available in the patient record.

12.9.2.3 Follow-up care, based on the findings of investigations/consultations performed outside the organisation, are noted in the patient record.

12.9.3 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation at another health facility and/or treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

12.9.3 Criteria

12.9.3.1 There is a documented process for transferring patients to other organisations.

Linked criteria:
1.2.5.4
12.9.3.6

12.9.3.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

12.9.3.3 The process for transferring the patient considers transportation needs.

12.9.3.4 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

12.9.3.5 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

12.9.3.6 A copy of the transfer summary is available in the patient record.

Critical criterion

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
12.9.3.1

12.9.3.7 The health organisation agreeing to receive the patient is noted in the patient's record.

12.9.4 *There is an organised process to appropriately discharge patients.*

Standard Intent

The organisation begins to plan for the patients' continuing needs as early in the care process. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

The summary contains at least:

a) the reason for admission
b) the diagnosis of main and significant illnesses
c) the results of investigations that will influence further management
d) all procedures performed
e) the patient's condition at discharge
f) discharge medications
g) follow-up arrangements.

12.9.4 Criteria

12.9.4.1 There is a documented process to appropriately discharge patients.

Root criterion
Linked criteria:
1.2.5.4, 1.3.2.1

12.9.4.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

Compliance for this criterion and the following will be verified through ***patient record audits***

12.9.4.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow-up instructions may be provided to the patient by the doctor or by the nurse, following instructions from the doctor.

The instructions should include medications, wound care, possible complications, return for follow-up care, when and where to obtain urgent care, etc.

12.9.4.4 A discharge summary, which includes at least items a) to g) in the intent statement, is written~~,~~ by the medical practitioner when each patient is discharged.

This criterion and the next apply to the discharge summary completed by the medical practitioner and not to the nurses' discharge notes. Where a discharge summary has only been partially completed, i.e. does not include all items a) to g) it will be scored PC. A nurse's discharge notes are not acceptable and is scored NC.

12.9.4.5 Each record contains a copy of the discharge summary.

12.10 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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/co-ordinating quality improvement structures or systems.

Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) patient assessment
b) surgical procedures carried out
c) the use of antibiotics and other medications and medication errors
d) the use of anaesthesia
e) the use of blood and blood products
f) patient and family expectations and satisfaction.

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.

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

Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, for example, monitoring the checking of emergency trolley over time, will be scored PC.

12.10.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

12.10.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits. These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings or specialised investigative studies, e.g. APACHE III. An indicator, in this context, is a measure used to determine improvements in clinical care over time.

Examples:

1. the number of bed sores/post-operative wound infections
2. nosocomial infection rates (barrier nursing/hand washing)
3. the percentage of partograms correctly completed
4.. the caesarean section rate.

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

12.10.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level. Where the documentation (patient record) audit is a hospital-wide multidisciplinary process that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

12.11 Patient Rights

12.11.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

12.11.1 Criteria

12.11.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

12.11.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria: *5.2.1.1-3* *6.1.2.1*

12.11.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion: 5.4.1.1

12.12 Prevention and Control of Infection

12.12.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

12.12.1 Criteria

12.12.1.1 The department identifies the procedures and processes associated with the risk of infection~~,~~ and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in the~~ir~~ department. Such documentation must form part of the organisation-wide infection control processes. *Linked criterion:* *9.2.1.1*

12.12.1.2 Infection control processes includes prevention of the spread of respiratory tract infections.

12.12.1.3 Infection control processes includes prevention of the spread of urinary tract infections.

12.12.1.4 Infection control processes includes prevention of the spread of infection through intravascular invasive devices.

12.12.1.5 Infection control processes includes prevention of the spread of infection through surgical wounds.

12.13 Risk Management

12.13.1 *The department/service implements risk management processes.*

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

12.13.1 Criteria

12.13.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

12.13.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
12.6.2.5 and 6

12.13.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

12.13.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

12.13.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 13 CRITICAL CARE

OVERVIEW OF CRITICAL CARE STANDARDS

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and co-ordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up. Activities specific to the critical care setting, whether for adult, paediatric or neonatal patients are provided in addition to the basic patient care and are assessed on the relevant services provided by the specific unit or service.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, law and regulation, an individual's particular skills, knowledge and experience, and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medication, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Continuity of Care
From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation.

Processes for continuity and Coordination of care among medical practitioners, nurses and other health service providersmust be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure Coordination of care.

Standards

13.1 Coordination of Patient Care

13.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

13.1.1 Criteria

13.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers, i.e. doctors and nurses.

Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists. It is important to assess the availability of doctors, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

13.1.1.2 The individuals responsible for patient care are qualified.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels, bed occupancy levels, etc.

The level of qualifications required would be dependent on the category of the relevant hospital. For example, a qualified general registered nurse with supervisory or management experience could be suitable as a ward manager) in a l district hospital, while a referral level hospital would need a registered nurse with advanced nursing as well as management qualifications.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
13.4.1.2, 13.6.1.1, 13.6.2.1

13.1.1.3 The individuals responsible for patient care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times.
***Patient interviews** will reveal whether staff members introduced themselves to patients.*

Linked criterion:
13.5.3.3

13.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

13.1.2 Criteria

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

Root criterion

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 criterion:
1.3.2.4

13.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (doctors, nurses, professions allied to medicine, social workers, etc.) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record.

Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

13.1.2.3 Information exchanged includes a summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criterion:
13.5.1.1

13.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

13.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.
Methods of verifying signatures and designations could include:

- *names and designations printed below signatures*
- *stamps indicating names and designations and/or*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

13.1.2.6 The date of each patient record entry can be identified.

Records must follow a chronological order to allow for a logical flow of information. Compliance will be verified during the ***patient record audit.***

13.1.2.7 The time of each patient record entry can be identified.

13.2 Facilities and Equipment

13.2.1 Adequate resources are available for the provision of safe care to patients in the ward.

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate toilet and bathing facilities for the number of patients in the ward, as determined by national legislation.

Where there is a neonatal ICU, there is a temperature-controlled nursery and it has:

- suitable bassinettes
- photo-therapy lights
- a panel for viewing babies
- a designated area for preparing infant feeds
- a fridge for milk feeds only
- facilities allocated for washing utensils used when preparing infant feeds.

There is adequate lighting and ventilation.

Nurse call systems are available at bedsides and in bathrooms and toilets and are connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily. Each ward is provided with a socket outlet that is connected to the emergency power supply.

A resuscitation trolley is available at the point of need within 1 minute. In addition, there is access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any patient collapsing. Resuscitation equipment includes at least:

- a defibrillator with adult paddles / pads (and infant paddles / pads where applicable)
- an ECG monitor
- a CPR board (if required)
- suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters

- a bag-mask manual ventilator;
- a range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable
- an introducer /stylet for endotracheal intubation
- a syringe to inflate the ETT cuff
- oropharyngeal tubes
- equipment to perform an emergency cricothyroidotomy – (needle and surgical)
- appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
- plasma expanders
- pulse oximeter.

13.2.1 Criteria

13.2.1.1 Patient and staff accommodation and equipment is adequate to meet patient care needs.

Root criterion.

There should be adequate office space for personnel; clean, hygienic sluice rooms, treatment and dressing rooms; demonstration rooms, adequate, tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients, as well as the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6
29.2.1.1

13.2.1.2 Oxygen and vacuum supplies meet the needs of patients for care.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. There must also be enough functional flow-meters.

Any evidence of infection control deficiencies, e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9 (Prevention and Control of Infections).

Linked criteria:
29.2.2.1, 29.2.3.2

13.2.1.3 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture.

Linked criterion:

31.2.1.5

13.2.1.4 Resuscitation equipment is available in accordance with the policies of the organisation.

Critical criterion

Must include at least the items mentioned in the Intent statement and according to national requirements.

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or AED within 3 minutes of any patient collapsing.

Linked criterion:
30.2.1.2

13.2.1.5 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

13.2.1.6 Each patient has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess whether responses are effective by interviewing patient/guardian and patient complaints.

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criterion:
29.2.1.2

13.2.1.7 Electricity and water is available in accordance with the policies of the organisation.

Ward/unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

13.2.1.8 Where there is a neonatal ICU, there is a dedicated area for preparing infant feeds.

Where there is no dedicated milk kitchen, there is a designated area for preparing infant feeds.

Where feeds are prepared for a 24 hour period, suitable refrigeration and feed warming methods are available.

Protective clothing is available and the personnel maintain good infection control practices.

This criterion cannot be marked NA just because the hospital is considered a "Baby Friendly" facility.

13.2.2. Specific resources are available for the provision of safe care to patients in the critical care unit.

Standard Intent

Professional guidelines for critical care services recommend the personnel and resources required to manage the service safely. The personnel in the ward are in possession of these guidelines, and ensure that the recommendations are implemented. These guidelines provide norms for staffing a critical care unit, and also for the services and facilities required.

13.2.2 Criteria

13.2.2.1 Current guidelines for the provision of critical care services and facilities are followed.

13.2.2.2 Staffing of the service complies with accepted staffing norms for critical care services.

13.2.2.3 Available medical equipment complies with accepted norms for critical care services.

13.2.2.4 Where resuscitation, intensive care, life support or critical monitoring equipment is used that does not have built-in battery backup units, there is an uninterruptible power supply (UPS) that complies with relevant requirements and regularly serviced and tested.

13.3 Clinical Practice Guidelines

13.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation.

Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits.

This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

13.3.1 Criteria

13.3.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

Guidelines/protocols "relevant to the patients and services" are assessed in each department according to the disease profiles of the patients admitted.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.
In the absence of guidelines, this criterion will be scored NC.

Linked criterion:
1.3.2.2

13.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criterion:
8.2.1.4

13.3.1.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

13.4 Assessment of Patients

13.4.1 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters a ward, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations. These findings are used throughout the care process to evaluate patient progress and provide information regarding the need for re-assessment. It is essential that assessments are well documented and can be easily retrieved from the patient's record.

The health organisation determines the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

13.4.1 Criteria

13.4.1.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care.

Root criterion

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy. Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

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

Linked criteria:
1.3.2.1
13.1.2.2, 13.4.2.1, 13.4.3.1

13.4.1.2 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of medical notes made in the patient record by the doctor, nurse or relevant clinical personnel will affect the outcome of the audit process. The signature and designation of the individual making entries into the patients' records must be identifiable.*

Linked criterion:
13.1.1.2

13.4.1.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline. The absence of medical notes by relevant clinical personnel, in the patient record will affect the outcome of the audit process.

Refer to criterion 13.4.1.1

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

13.4.1.4 Policies and procedures ensure that assessments are performed within appropriate time frames and that they are adequately documented in the patients' records.

Time frames for the assessment of patients need to be established for each discipline, e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

13.4.2 Each patient has an initial assessment that complies with current policies, procedures and guidelines.

Standard Intent

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process is modified in accordance with national guidelines and protocols. The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge is initiated during the initial assessment process.

When the medical assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

13.4.2 Criteria

13.4.2.1 Each patient admitted has an initial assessment that meets organisational policy.

Root criterion.

Documented evidence in the form of a detailed policy and procedure or guideline is provided. To ensure Coordination of patient care, all members of the team should be included in the formulation of this policy framework, especially doctors and nurses.

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

Linked criteria:
13.4.1.1, 13.4.3.1

13.4.2.2 The initial assessment includes health history.

Compliance is measured in the relevant areas in the patient's records. This criterion will be scored PC if doctors' notes or notes by relevant clinical personnel are not available.

Compliance will be verified during the ***patient record audit.*** *This applies to all the following criteria relevant to this standard.*

13.4.2.3 The initial assessment includes physical examination.

If medical practitioner notes are not available this will be scored NC.
Vital sign measurement only is not considered a physical examination.

The only exceptions are where physical assessments are undertaken by nurses with special training i.e. SEs 13, 14 and 24.

13.4.2.4 The initial assessment includes functional examination, where applicable.

13.4.2.5 The initial assessment includes social and economic assessment, where applicable.

13.4.2.6 The initial assessment includes psychological assessment, where applicable.

13.4.2.7 The initial assessment includes cultural assessment, where applicable.

13.4.2.8 The initial assessment results in an initial diagnosis.

13.4.2.9 The initial assessment results in the identification of the patient's medical, nursing or other health needs.

13.4.3 Health professionals responsible for patient care collaborate to analyse and integrate assessment information.

Standard Intent

A patient benefits most when the personnel responsible for the patient work together

to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established, and care decisions are made.

13.4.3 Criteria

13.4.3.1 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

There should be evidence that all clinical professionals dealing with the patient have contributed to the patient's record.

Compliance with the requirements of this and the following criteria will be verified during the ***patient record audit.*** *If notes by a relevant clinical professional are not found, the criterion will be scored PC.*

Linked criteria:
13.4.1.1, 13.4.2.1

13.4.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

13.4.3.3 Patient needs are prioritised on the basis of assessment results.

13.4.3.4 The patient and/or the family participate in the decisions regarding the priority needs to be met.

Compliance will be verified during ***patient interviews and/or*** *the* ***patient record audits****.*

13.5 Patient Care

13.5.1 The care provided to each patient is planned and written in the patient's record.

Standard Intent

A single, integrated plan is preferable to a separate care plan recorded by each health professional.

Collaborative care and treatment team meetings or similar patient discussions are recorded.

Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.

The organisation decides:

- which orders must be written rather than verbal
- who is permitted to write orders
- where orders are to be located in the patient record.

The method used must respect the confidentiality of patient care information.

13.5.1 Criteria

13.5.1.1 The planned care is provided and noted in the patient's record.

Root criterion
Compliance will be verified during the ***patient record audit****.*

Linked criterion:
13.1.2.3

13.5.1.2 All procedures and diagnostic tests ordered and performed are written into the patient's record.

The term "written" here implies documented evidence. Such evidence may include nurses' and doctors' notes, as well as printed reports, which are filed in the patient record.

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

13.5.1.3 The results of procedures and diagnostic tests performed are available in the patient's record.

This criterion will be scored PC if the results are not initialled by the doctor, the treatment plan does not indicate action taken, or the nursing notes do not indicate that the doctor was informed.

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

13.5.1.4 Re-assessments are documented in the patient's record.

13.5.1.5 The patient's plan of care is modified when the patient's needs change.

13.5.2 Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

Stadard Intent

Some patients are considered "high-risk" because of their age, condition or the critical nature of their needs. Children and the elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Policies and procedures are important. They help the personnel understand these patients and services and respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training staff in their implementation.

The special facilities and safety measures required by children need to be specified.

It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required for the care team to work effectively
- special consent considerations
- monitoring requirements
- special qualifications or skills of the personnel involved in the care process
- the resuscitation equipment available and how to use it, including equipment for children.

Clinical guidelines should be incorporated in the process because there are several criteria requiring guidelines to be used. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high-risk patients and procedures, e.g.:

a) the care of emergency patients
b) the handling, use and administration of blood and blood products
c) the management of contaminated blood supplies (expired, opened or damaged container)
d) the care of patients on life support or those who are comatose
e) the care of patients with communicable diseases
f) the care of immuno-suppressed patients
g) the care of patients on dialysis
h) the use of restraint and the care of patients in restraint
i) the care of frail, dependent, elderly patients
j) the care of young, dependent children
k) the security of newborn babies, where applicable
l) the care of adolescents.

13.5.2 Criteria

13.5.2.1 Policies and procedures for identified high-risk patients and procedures, which include at least items a) to l) in the intent statement above, are implemented.

The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training the personnel to implement them correctly.

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

Linked criteria:
1.3.2.1
7.2.5.1
9.2.1.8

13.5.1.4 The personnel are trained and use the policies and procedures to guide care.

Where policies and procedures refer to patient care the same rule as 13.4.2.1 is applied, i.e. compliance will be measured against the relevant areas in the patients' records during the ***record audit process.***

By implication, if the policies are implemented, the personnel can be considered to have been trained and this criterion will be scored accordingly. This "training" could take the form of formal in-service training, introduction at orientation to policies, discussions at departmental meetings, case studies, etc.

13.5.2 Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Standard Intent

This section deal with the process of obtaining informed consent from patient and does NOT refer to providing health education in general, which is dealt with in Standard 13.8.

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent. For example, consent may be given verbally, by signing a consent form, or through some other mechanism. Patients and families understand who may give consent, in addition to the patient.

Designated personnel are trained to inform patients and to obtain and document patient consent, e.g. a doctor for a surgical procedure or a nurse for HIV testing. These staff members clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications
- consideration of the surgical and non-surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written, informed consent. Leaders document the processes for obtaining informed consent.

The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledges full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

13.5.3 Criteria

13.5.3.1 There is a documented process for obtaining informed consent.

*This section refers to all instances where patients give informed consent and compliance will be verified during the patient **record audit**.*

If consent was not required for the patient records audited, this whole standard becomes NA.

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 13.5.3.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC because the process has not been implemented.

Linked criterion:
5.6.1.1

13.5.2.2 Patients are informed about their condition, and the proposed treatment.

13.5.2.3 Patients know the identity of the medical practitioner or other professional practitioner responsible for their care.

Linked criterion:
13.1.1.3

13.5.2.4 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion

*Compliance will be verified during the **patient record audit.***
If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information indicated in the relevant criteria above. This criterion and the relevant criteria above will be scored C.

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria above will receive the same score.

Linked criterion:
5.6.1.1

13.5.3 Pre- and post-operative assessments are documented.

Standard Intent

The preoperative anaesthetic assessment determines whether the patient is a good candidate for the planned surgery and may significantly influence the pre- and intra-operative management. The clinical assessment and results of investigations must be available to the doctor performing the assessment. In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition. Appropriate re-assessments are essential to modify and guide effective treatment.

A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report is available within a time frame needed to provide post-surgical care to the patient. Post-operative monitoring is appropriate to the patient's condition and the procedure performed.

Results of monitoring influence intra and post operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

13.5.4 Criteria

13.5.4.1 The patients' initial medical assessment is documented before anaesthesia.

There is documented evidence in the form of a detailed policy or guideline indicating who may perform this assessment, i.e. the person responsible for administering the anaesthetic.

Compliance with criteria 13.5.4.1 to 5 will be verified during the ***patient record audit.***

13.5.4.2 The patient's pre-operative diagnosis is recorded before anaesthesia.

13.5.4.3 A post-operative diagnosis is documented.

13.5.4.4 The names of the surgeon, and the names of other personnel as required by law, are documented.

13.5.4.5 The patient's physiological status is monitored during the immediate post-surgery period.

13.5.5 The organisation implements processes to support the patient in pain management.

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and re-assessment
- communicate with, and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- educate health service providersin pain assessment and management.

13.5.5 Criteria

13.5.5.1 The assessment process makes provision for patients in pain to be identified.

13.5.3.2 Patients in pain receive care according to pain management guidelines.

There should be evidence that all clinical professionals dealing with the patient's pain management, have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment. These records will also be evaluated.

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

Linked criterion:
1.3.2.1

13.5.5.3 Patients and families are educated about pain and pain management.

Compliance will be verified during the ***patient record audit and patient interviews.***

13.5.5.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.4

13.5.6 The organisation develops processes to manage end-of-life care.

Standard Intent

Dying patients have unique needs for respectful, compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all personnel are made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the organisation includes:

a) providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) sensitively addressing issues such as autopsy and organ donation
c) involving the patient and family in all aspects of care
d) responding to the psychological, emotional, spiritual and cultural concerns of the patient and family.

13.5.6 Criteria

13.5.6.1 Policies and procedures regarding end-of-life care, at least including elements a) to d) in the intent statement, are implemented.

*Evidence can be sought in **patient records** and by observation of the care process. Another example would be the manner in which the policy on withholding resuscitation is applied.*

Linked criteria:
1.3.2.1
5.4.2.1

13.5.6.2 The patient and the family/guardian are involved in care decisions.

The decision should be the patient's in terms of whom they consider the most important individual to support them at this time.

13.5.6.3 Pain and primary or secondary symptoms are managed.

13.5.6.4 Interventions address patient and family religious and cultural concerns.

13.6 Medication

13.6.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

13.6.1 Criteria

13.6.1.1 Policies and procedures that guide the safe prescribing, ordering, storage and administration of medications are implemented.

Root criterion

These policies need to be developed by all the role-players, i.e. medical practitioners, nurses and pharmacists.

National regulations related to prescription and administration will apply.

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

Linked criteria:
1.3.2.1
13.1.1.2
21.3.1.1

13.6.1.2 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
13.6.2.3
21.3.1.1

13.6.1.3 Only those permitted by the organisation and by relevant laws and regulations prescribe medication.

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

Linked criterion:
13.1.1.2

13.6.1.4 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the patient's medical practitioner and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over-the-counter and homeopathic medicines.

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

Linked criterion:
21.3.1.1

13.6.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, medical practitioner, nurse, and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed, and to evaluate the patient for adverse effects.

The organisation follows national requirements for the reporting of adverse effects. Doctors, nurses, and pharmacists are expected to report reactions that are

suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

13.6.2 Criteria

13.6.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:
13.1.1.2

13.6.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

13.6.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
13.6.1.2
21.3.1.1

13.6.2.4 Health professionals monitor medication effects on patients collaboratively.

***Patient record audits** should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the medical practitioner.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional information may be required. For example, plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

13.6.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

*An **adverse drug reaction** (**ADR**) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.*

*Compliance is verified during the **patient record audit.***

Documentation showing that the reaction was reported to the medical practitioner and the pharmacist will be sought.

Linked criteria:
7.1.1.7
13.13.1.2
21.6.1.1, 21.9.1.2

13.6.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording ~~of~~ medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
13.13.1.2
21.6.1.1, 21.9.1.2

13.6.2.7 The medications prescribed for and administered to each patient are recorded.

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

13.6.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

13.6.3 Criteria

13.6.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerators, etc.) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant staff members only.

An unlocked refrigerator in an unlocked room will be scored NC.

13.6.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

The laws and regulations or organisational policy will determine the nature of these medications.

Linked criterion:
21.5.1.11

13.6.3.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion

Compliance needs to be measured against the medicine control regulations.
Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

13.6.3.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion

National regulations will apply, but must include at least the following:

- *name of ward and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

13.6.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

13.6.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

13.6.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication.

Linked criterion:
21.5.1.9

13.6.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion

Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

13.6.3.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

13.7 Food and Nutrition Therapy

13.7.1 Food and nutrition therapy appropriate for the patient and consistent with his or her clinical care is regularly available.

Standard Intent

A qualified caregiver orders appropriate food or other nutrients. The patient participates in planning and selecting foods, and the patient's family may, when appropriate, participate in providing food. They are educated as to which foods are contraindicated, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status.

The nutritional status of the patients is monitored.

13.7.1 Criteria

13.7.1.1 Food, appropriate to the patient, is regularly available.

Compliance is verified during interviews with personnel and patients, especially regarding times of meals and the availability of special diets.
Menus and meal times will be checked.

Linked criterion:
26.4.1.3

13.7.1.2 An order for food, based on the patients' nutritional status and needs, is recorded in the patient's file.

*Compliance will be verified during the **patient record audit**, especially as it relates to the patient's assessment, the care plan and the identification of special dietary requirements. Prescribed diets are ordered and delivered to the patient.*

13.7.1.3 When families provide food, they are educated about the patient's diet limitations.

*Compliance will be verified during the **patient record audit***

Linked criteria:
13.8.1.3

13.7.1.4 Patients assessed as being at nutrition risk receive nutrition therapy.

Patients could include malnourished children, patients unable to take normal meals for whatever reason, e.g. inability to swallow, specific disease processes. This could include the provision of nutritional supplements or the provision of full parenteral nutrition.

This criterion and those that follow apply only to nutrition therapy and do not include special diets.

*Compliance of all these criteria will be verified during the **patient record audit.***

13.7.1.5 A collaborative process is used to plan, deliver and monitor nutrition therapy.

*This should include the involvement of a dietician if available. Compliance will be verified during the **patient record audit.***

Linked criteria:
1.3.2.1
21.3.1.1

13.7.1.6 Nutrition therapy provided, either oral or intravenous, is written in the patient's record.

13.7.1.7 Response to nutrition therapy is monitored and recorded.

This may take the form of weight/mass checks, laboratory tests for protein and/or lipid levels etc.

13.8 Patient and Family Education

13.8.1 Education supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care, and continue care at home.
Variables like educational literacy, beliefs and limitations are taken into account.

Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administration, they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment. Community organisations that support health promotion

and disease prevention education are identified and, when possible, on-going relationships are established.

*Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.*

13.8.1 Criteria

13.8.1.1 Patients and families indicate that they have been informed about their diagnosis.

13.8.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
5.3.1.2

13.8.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use, etc.

Linked criterion:
13.7.1.3

13.8.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

13.9 Continuity of Care

13.9.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and Coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providersmay be involved in providing care. Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

13.9.1 Criteria

13.9.1.1 Established criteria or policies and procedures that guide the movement of patients within the organisation are implemented.

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

13.9.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

13.9.1.3 Continuity and Coordination are evident throughout all phases of patient care.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

13.9.1.4 The record of the patient accompanies the patient when transferred within the organisation.

13.9.2 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation and treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient.

Transfer may be a brief process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

13.9.2 Criteria

13.9.2.1 There is a documented process for transferring patients to other organisations.

Linked criteria:
1.2.5.4
13.9.3.6

13.9.2.2 The referring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

13.9.2.3 The process for transferring the patient considers transportation needs.

13.9.2.4 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

13.9.2.5 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

Compliance for this criterion and the following will be verified during the ***patient record audit****.*

13.9.2.6 A copy of the transfer summary is available in the patient record.

Critical criterion

Compliance for this criterion and the following will be verified during the patient record audit.

Linked criterion:
13.9.3.1

13.9.2.7 The health organisation agreeing to receive the patient, is noted in the patient's record.

13.10 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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 or management or co-ordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) patient assessment
b) surgical procedures carried out
c) the use of antibiotics and other medications and medication errors
d) the use of anaesthesia
e) the use of blood and blood products
f) patient and family expectations and satisfaction;

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.

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

Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

13.10.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

13.10.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies, e.g. APACHE III. An indicator, in this context, is a measure used to determine improvements in clinical care over time.

Examples:
1. the number of bed sores/post-operative wound infections; and
2 nosocomial infection rates (barrier nursing/hand washing).

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

13.10.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.
Where the documentation (patient record) audit is a hospital-wide multidisciplinary process that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

13.11 Patient Rights

13.11.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

13.11.1 Criteria

13.11.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against legislation, where applicable.

Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation. This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

13.11.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

13.11.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

13.12 Prevention and Control of Infection

13.12.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

13.112.1 Criteria

13.13.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

13.12.1.2 Infection control processes includes prevention of the spread of respiratory tract infections.

13.12.1.3 Infection control processes includes prevention of the spread of urinary tract infections.

13.12.1.4 Infection control processes includes prevention of the spread of infection through intravascular invasive devices.

13.12.1.5 Infection control processes includes prevention of the spread of infection through surgical wounds.

13.13 Risk Management

13.13.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

13.13.1 Criteria

13.13.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g.

patient, staff and visitor-related risks, financial, and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

13.13.1.2 A system for monitoring incidents, near misses, sentinel and adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents, near misses, and adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
13.6.2.5 and 6

13.13.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

13.13.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

13.13.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 14 OBSTETRIC AND MATERNITY CARE

OVERVIEW OF OBSTETRIC AND MATERNITY CARE STANDARDS

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and co-ordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up. Activities specific to the obstetric/maternity care setting, whether for adult or neonatal patients are provided in addition to the basic patient care and are assessed on the relevant services provided by the specific unit or service.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, law and regulation, an individual's particular skills, knowledge and experience, and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medication, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Continuity of Care:
From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation. Processes for continuity and coordination of care among medical practitioners, nurses and other health service providersmust be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure Coordination of care.

Standards

14.1 Coordination of Patient Care

14.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

14.1.1 Criteria

14.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers, i.e. doctors and nurses. Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists.

It is important to assess the availability of doctors, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

14.1.1.2 The individuals responsible for the patient's care are qualified.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels, bed occupancy levels, etc.

The level of qualifications required would be dependent on the category of the relevant hospital. For example, a qualified general registered nurse with supervisory or management experience could be suitable as a ward manager) in a district hospital, while a referral hospital would need a registered nurse with advanced nursing as well as management qualifications.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
14.4.1.2, 14.6.1.1, 14.6.2.1

14.1.1.3 The individuals responsible for the patient's care are identified and made known to the patient and other staff.

Name badges should be worn by all staff members at all times. **Patient interviews** will reveal whether staff members introduce themselves to patients.

Linked criterion:

14.5.3.3

14.1.1.4 The requirements of antenatal, labour and postnatal wards and nurseries are individually included in the staffing requirements.

14.1.1.5 A registered midwife and/or medical practitioner is present at every birth.

14.1.1.6 Specialists are available for consultation.

14.1.1.7 At least one person is available at all times who is qualified (medical practitioner or advanced midwife) in the management of maternal and neonatal emergencies.

14.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate. The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

14.1.2 Criteria

14.1.2.1 The patient's clinical records are completed according to guidelines determined by the organisation.

Root criterion

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 relevant criteria in this document.*

Linked criterion:
1.3.2.4

14.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (doctors, nurses, professions allied to medicine, social workers, etc) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record. Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

14.1.2.3 Information exchanged includes a summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criterion:
14.5.1.1

14.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

14.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.
Methods of verifying signatures and designations could include;

- *names and designations printed below signatures;*
- *stamps indicating names and designations; and/or*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and

initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

14.1.2.6 The date of each patient record entry can be identified.

Records must follow a chronological order to allow for a logical flow of information. Compliance will be verified during the ***patient record audit.***

14.1.2.7 The time of each patient record entry can be identified.

Patient records include time of arrival at the facility and each time that the patient is assessed by a health professional.

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

14.2 Facilities and Equipment

14.2.1 *Adequate resources are available for the provision of safe care to patients in the ward.*

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate toilet and bathing facilities for the number of patients in the ward, as determined by national legislation.

Each delivery room has at least:

a) one cardio-tocograph machine
b) an infant warming and resuscitation cart
c) an incubator with adjustable temperature and separate oxygen supply
d) a fetal monitor
e) equipment for inhalation analgesia.

There is a temperature-controlled nursery and it has:

- suitable bassinettes
- photo-therapy lights
- a panel for viewing babies
- a designated area for preparing infant feeds

- a fridge for milk feeds only
- facilities allocated for washing utensils used when preparing infant feeds.

There is adequate lighting and ventilation.

Nurse call systems are available at bedsides and in bathrooms and toilets and are connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily. Each ward is provided with a socket outlet that is connected to the emergency power supply.

A resuscitation trolley is available at the point of need within 1 minute. In addition, there is access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any patient collapsing. Resuscitation equipment includes at least:

- a defibrillator with adult paddles / pads (and infant paddles / pads where applicable)
- an ECG monitor
- a CPR board (if required)
- suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- a bag-mask manual ventilator
- a range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable
- an introducer /stylet for endotracheal intubation
- a syringe to inflate the ETT cuff
- oropharyngeal tubes
- equipment to perform an emergency cricothyroidotomy – (needle and surgical)
- appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
- plasma expanders.

14.2.1 Criteria

14.2.1.1 Patient and staff accommodation and equipment is adequate to meet patient care needs.

Root criterion.

There should be adequate office space for personnel; clean, hygienic sluice rooms, treatment and dressing rooms; demonstration rooms, adequate, tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients, as well as the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6
29.2.1.1

14.2.1.2 Oxygen and vacuum supplies meet the needs of patients for care.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. There must also be enough functional flow-meters.

Any evidence of infection control deficiencies e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9 (Prevention and Control of Infections).

Linked criteria:
29.2.2.1, 29.2.3.2

14.2.1.3 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture..

Linked criterion:
31.2.1.5

14.2.1.4 Resuscitation equipment is available in accordance with the policies of the organisation.

Critical criterion
Must include at least the items mentioned in the Intent statement and according to national requirements

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required. A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or automated external defibrillator *(AED) within 3 minutes of any patient collapsing.*

Linked criterion:
30.2.1.2

14.2.1.5 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

14.2.1.6 Each patient has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess whether responses are effective by interviewing patients/guardian and reviewing patient and customer complaints.

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criterion:

29.2.1.2

14.2.1.7 Electricity and water is available in accordance with the policies of the organisation.

Ward/unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

14.2.2 *Specific resources are available for the provision of safe care to patients in the obstetric and maternity unit/ward.*

Standard Intent

Professional guidelines for obstetric/maternity care services recommend the personnel and resources required to manage the service safely. The personnel in the ward are in possession of these guidelines, and ensure that the recommendations are implemented. These guidelines provide norms for staffing an obstetric/maternity care unit, and also for the services and facilities required.

14.2.2 Criteria

14.2.2.1 Current guidelines for the provision of obstetric/maternity care services and facilities are followed.

14.2.1.8 Staffing of the service complies with accepted staffing norms for obstetric/maternity care services.

14.2.1.9 Available medical equipment complies with accepted norms for obstetric/maternity care services.

14.2.1.10 Where resuscitation, intensive care, life support or obstetric/maternity monitoring equipment is used that does not have built-in battery backup units, there is an uninterruptible power supply (UPS) that complies with relevant requirements and regularly serviced and tested.

14.2.1.11 There is a dedicated area for the preparation of infant feeds.

14.3 Clinical Practice Guidelines

14.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of

the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits.

This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

14.3.1 Criteria

14.3.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

Guidelines/protocols "relevant to the patients and services" are assessed in each department according to the disease profiles of the patients admitted.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

In the absence of guidelines, this criterion will be scored NC.

Linked criterion:
1.3.2.2

14.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing. If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criterion:
8.2.1.4

14.3.1.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

14.4 Assessment of Patients

14.4.1 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters a ward, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in

which care is being provided.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations.

These findings are used throughout the care process to evaluate patient progress and provide information regarding the need for re-assessment. It is essential that assessments are well documented and can be easily retrieved from the patient's record.

The health organisation determines the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

14.1.1 Criteria

14.4.1.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care.

Root criterion

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy. Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

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

Linked criteria:
1.3.2.1
14.1.2.2, 14.4.2.1, 14.4.3.1

14.4.1.2 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of medical notes made in the patient record by the doctor, nurse or relevant clinical personnel will affect the outcome of the audit process. The signature and designation of the individual making entries into the patients' records must be identifiable.*

Linked criterion:
14.1.1.2

14.4.1.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline.
The absence of medical notes documented by relevant clinical personnel , in the patient record will affect the outcome of the audit process.
Refer to criterion 14.4.1.1

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

14.4.1.4 Policies and procedures ensure that assessments are performed within appropriate time frames and that they are adequately documented in the patients' records.

Time frames for the assessment of patients need to be established for each discipline, e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

14.4.2 Each patient has an initial assessment that complies with current policies, procedures and guidelines.

Standard Intent

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process is modified in accordance with national guidelines and protocols. The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge is initiated during the initial assessment process. When the medical assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

14.4.2 Criteria

14.4.2.1 Each patient admitted has an initial assessment that meets organisational policy.

Root criterion.

Documented evidence in the form of a detailed policy and procedure or guideline is provided. To ensure Coordination of patient care, all members of the team should be included in the formulation of this policy framework, especially doctors and nurses.

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

Linked criteria:
14.4.1.1, 14.4.3.1

14.4.2.2 The initial assessment includes health history.

Compliance is measured in the relevant areas in the patient's records. This criterion will be scored PC if doctors' notes or notes by relevant clinical personnel, other than nurses, are not available.

Compliance will be verified during the ***patient record audit.*** *This applies to all the following criteria relevant to this standard.*

14.4.2.3 The initial assessment includes physical examination.

If medical practitioner notes are not available this will be scored NC.

Vital sign measurement only is not considered a physical examination.

The only exceptions are where physical assessments are undertaken by nurses with special training i.e. SEs 13, 14 and 24.

14.4.2.4 The initial assessment includes functional examination, where applicable.

14.4.2.5 The initial assessment includes social and economic assessment, where applicable.

14.4.2.6 The initial assessment includes psychological assessment, where applicable.

14.4.2.7 The initial assessment includes cultural assessment, where applicable.

14.4.2.8 The initial assessment includes antenatal history.

14.4.2.9 The initial assessment includes maternal and fetal examination.

Linked criterion:
7.2.5.2

14.4.2.10 The initial assessment results in an initial diagnosis.

14.4.2.11 The initial assessment results in the identification of the patient's medical, nursing or other health needs.

14.4.3 Health professionals responsible for patient care collaborate to analyse and integrate assessment information.

Standard Intent

A patient benefits most when the personnel responsible for the patient work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established, and care decisions are made.

14.4.3 Criteria

14.4.3.1 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

There should be evidence that all clinical professionals dealing with the patient have contributed to the patient's record.

Compliance with the requirements of this and the following criteria will be verified during the ***patient record audit.*** *If notes by a relevant clinical professional are not found, the criterion will be scored PC.*

Linked criteria:
14.4.1.1, 14.4.2.1

14.4.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

14.4.3.3 Patient needs are prioritised on the basis of assessment results.

14.4.3.4 The patient and/or the family participate in the decisions regarding the priority needs to be met.

Compliance will be verified during ***patient interviews and/or*** *the* ***patient record audits****.*

14.5 Patient Care

14.5.1 The care provided to each patient is planned and written in the patient's record.

Standard Intent

A single, integrated plan is preferable to a separate care plan recorded by each health professional.

Collaborative care and treatment team meetings or similar patient discussions are

recorded.

Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.

The organisation decides:

- which orders must be written rather than verbal
- who is permitted to write orders
- where orders are to be located in the patient's records.

The method used must respect the confidentiality of patient care information.

14.5.1 Criteria

14.5.1.1 The planned care is provided and noted in the patient's record.

Root criterion.
Compliance will be verified during the ***patient record audit****.*

Linked criterion:
14.1.2.3

14.5.1.2 All procedures and diagnostic tests ordered and performed are written into the patient's record.

The term "written" here implies documented evidence. Such evidence may include nurses' and doctors' notes as well as printed reports, which are filed in the patient record.

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

14.5.1.3 The results of procedures and diagnostic tests performed are available in the patient's record.

This criterion will be scored PC if the results are not initialled by the doctor, the treatment plan does not indicate action taken, or the nursing notes do not indicate that the doctor was informed.

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

14.5.1.4 Re-assessments are documented in the patient's record.

14.5.1.5 The maternal and fetal conditions and the progress of labour are recorded on a partogram in every labour.

14.5.1.6 The patient's plan of care is modified when the patient's needs change.

14.5.2 Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

Standard Intent

Some patients are considered "high-risk" because of their age, condition or the critical nature of their needs. Children are commonly in this group as they may not speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Policies and procedures are important. They help the personnel understand these patients and services and respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training staff in their implementation.

The special facilities and safety measures required by children need to be specified. It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required for the care team to work effectively
- special consent considerations
- monitoring requirements
- special qualifications or skills of the personnel involved in the care process
- the resuscitation equipment available and how to use it, including equipment for children.

Clinical guidelines should be incorporated in the process because there are several criteria requiring guidelines to be used. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high-risk patients and procedures, e.g.:

a) the care of emergency patients
b) methods of delivery
c) management of meconium stained liquor
d) Apgar scoring and evaluation
e) performing of episiotomies
f) the handling, use and administration of blood and blood products
g) the management of contaminated blood supplies (expired, opened or damaged container)
h) the care of patients with communicable diseases
i) the care of immuno-suppressed patients
j) the use of restraint and the care of patients in restraint
k) the care of young, dependent children
l) the security of newborn babies.

14.5.2 Criteria

14.5.2.1 Policies and procedures for identified high-risk patients and procedures, which include at least items a) to l) in the intent statement above, are implemented.

The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training the personnel to implement them correctly.

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

Linked criteria:
1.3.2.1
7.2.5.1
9.2.1.8

14.5.2.2 The personnel are trained and use the policies and procedures to guide care.

Where policies and procedures refer to patient care the same rule as 14.4.2.1 is applied, i.e. compliance will be measured against the relevant areas in the patients' records during the ***record audit process.***

By implication, if the policies are implemented, the personnel can be considered to have been trained and this criterion will be scored accordingly. This "training" could take the form of formal in-service training, introduction at orientation to policies, discussions at departmental meetings, case studies, etc.

14.5.3 Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Standard Intent

This section deal with the process of obtaining informed consent from patient and does NOT refer to providing health education in general, which is dealt with in Standard 14.8.

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent. For example, consent may be given verbally, by signing a consent form, or through some other mechanism. Patients and families understand who may give consent, in addition to the patient.

Designated personnel are trained to inform patients and to obtain and document patient consent, e.g. a doctor for a surgical procedure or a nurse for HIV testing. These staff members clearly explain any proposed treatments or procedures to the patient, and when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications

- consideration of the surgical and non-surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written, informed consent. Leaders document the processes for obtaining informed consent. The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledges full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

14.5.3 Criteria

14.5.3.1 There is a documented process for obtaining informed consent.

Root criterion

This section refers to all instances where patients give informed consent and compliance will be verified during the patient ***record audit****.*

If consent was not required for the patient records audited, this whole standard becomes NA.

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 14.5.3.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC, because the process has not been implemented.

Linked criterion:
5.6.1.1

14.5.3.2 Patients are informed about their condition and the proposed treatment.

14.5.3.3 Patients know the identity of the medical practitioner or other professional practitioner responsible for their care.

Linked criterion:
14.1.1.3

14.5.3.4 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion

*Compliance will be verified during the **patient record audit.***
If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information indicated in the relevant criteria above. This criterion and the relevant criteria above will be scored C.

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria above will receive the same score.

Linked criterion:
5.6.1.1

14.5.4 Pre- and post-operative assessments are documented.

Standard Intent

The preoperative anaesthetic assessment determines whether the patient is a good candidate for the planned surgery and may significantly influence the pre- and intra-operative management. The clinical assessment and results of investigations must be available to the doctor performing the assessment. In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition. Appropriate re-assessments are essential to modify and guide effective treatment.

A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report is available within a time frame needed to provide post-surgical care to the patient. Post-operative monitoring is appropriate to the patient's condition and the procedure performed. Results of monitoring influence intra- and post-operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

14.5.4 Criteria

14.5.4.1 The patients' initial medical assessment is documented before anaesthesia.

There is documented evidence in the form of a detailed policy or guideline indicating who may perform this assessment, i.e. the person responsible for administering the anaesthetic.

*Compliance with criteria 14.5.4.1 to 5 will be verified during the **patient record audit.***

14.5.4.2 The patient's pre-operative diagnosis is recorded before anaesthesia.

14.5.4.3 A post-operative diagnosis is documented.

14.5.4.4 The names of the surgeon, and the names of other personnel as required by law, are documented.

14.5.4.5 The patient's physiological status is monitored during the immediate post-surgery period.

14.5.5 The organisation implements processes to support the patient in managing pain.

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and re-assessment
- communicate with, and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs
- educate health service providersin pain assessment and management.

14.5.5 Criteria

14.5.5.1 The assessment process makes provision for patients in pain to be identified.

14.5.5.2 Patients in pain receive care according to pain management guidelines.

There should be evidence that all clinical professionals dealing with the patient's pain management have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment. These records will also be evaluated.

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

Linked criterion:
1.3.2.1

14.5.5.3 Patients and families are educated about pain and pain management.

Compliance will be verified during the ***patient record audit and patient interviews.***

14.5.5.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.4

14.5.6 *The organisation develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful, compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all personnel are made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the organisation includes:

a) providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) sensitively addressing issues such as autopsy and organ donation
c) involving the patient and family in all aspects of care
d) responding to the psychological, emotional, spiritual and cultural concerns of the patient and family.

14.5.6 Criteria

14.5.6.1 Policies and procedures regarding end-of-life care, at least including elements a) to d) in the intent statement are implemented.

*Evidence can be sought in **patient records** and by observation of the care process. Another example would be the manner in which the policy on withholding resuscitation is applied.*

Linked criteria:
1.3.2.1
5.4.2.1

14.5.6.2 The patient and the family/guardian are involved in care decisions.

The decision should be the patient's in terms of whom they consider the most important individual to support them at this time.

14.5.6.3 Pain and primary or secondary symptoms are managed.

14.5.6.4 Interventions address patient and family religious and cultural concerns.

14.6 Medication

14.6.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and

administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

14.6.1 Criteria

14.6.1.1 Policies and procedures that guide the safe prescribing, ordering and administration of medications are implemented.

Root criterion

These policies need to be developed by all the role-players i.e. medical practitioners, nurses and pharmacists.

National regulations related to medication prescription and administration will apply.

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

Linked criteria:
1.3.2.1
14.1.1.2
21.1.2.1

14.6.1.2 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
14.6.2.3
21.3.1.1

14.6.1.3 Only those permitted by the organisation and by relevant law and regulation prescribe medication.

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

Linked criterion:
14.1.1.2

14.6.1.4 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the medical practitioner and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over-the-counter and homeopathic medicines.

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

Linked criterion:
21.3.1.1

14.6.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, medical practitioner, nurse, and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed, and to evaluate the patient for adverse effects.

The organisation follows national regulations for the reporting of adverse effects. Doctors, nurses, and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

14.6.2 Criteria

14.6.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:
14.1.1.2

14.6.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

14.6.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
14.6.1.2
21.3.1.1

14.6.2.4 Health professionals monitor medication effects on patients collaboratively.

***Patient record audits** should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the medical practitioner.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional information may be required. For example, plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

14.6.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

*An **adverse drug reaction** (**ADR**) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.*

*Compliance is verified during the **patient record audit.***
Documentation showing that the reaction was reported to the medical practitioner and the pharmacist will be sought.

Linked criteria:
7.1.1.7
14.13.1.2
21.6.1.1, 21.9.1.2

14.6.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
14.13.1.2
21.6.1.1, 21.9.1.2

14.6.2.7 The medications prescribed for and administered to each patient are recorded.

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

14.6.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

14.6.3 Criteria

14.6.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerators, etc) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant personnel only.

An unlocked refrigerator in an unlocked room will be scored NC.

14.6.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

The laws and regulations or organisational policy will determine the nature of these medications.

Linked criterion:
21.5.1.11

14.6.3.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion
Compliance needs to be measured against the medicine control regulations.
Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

14.6.3.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion

National regulations will apply, but must include at least the following

- *name of ward and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number and*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

14.6.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

Linked criterion:
21.5.1.7

14.6.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

14.6.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication.

Linked criterion:
21.5.1.9

14.6.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion

Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

14.6.3.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

14.7 Food and Nutrition Therapy

14.7.1 Food and nutrition therapy appropriate for the patient and consistent with his or her clinical care is regularly available.

Standard Intent

A qualified caregiver orders appropriate food or other nutrients. The patient participates in planning and selecting foods, and the patient's family may, when appropriate, participate in providing food. They are educated as to which foods are contraindicated, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status.

The nutritional status of the patients is monitored.

14.7.1 Criteria

14.7.1.1 Food, appropriate to the patient, is regularly available.

Compliance is verified during interviews with personnel and patients, especially regarding times of meals and the availability of special diets.
Menus and meal times will be checked.

Linked criterion:
26.4.1.3

14.7.1.2 An order for food, based on the patients' nutritional status and needs, is recorded in the patient's file.

*Compliance will be verified during the **patient record audit**, especially as it relates to the patient's assessment, the care plan and the identification of special dietary requirements. Prescribed diets are ordered and delivered to the patient.*

14.7.1.3 When families provide food, they are educated about the patient's diet limitations.

*Compliance will be verified during the **patient record audit**.*
Linked criteria:
14.8.1.3

14.7.1.4 Patients assessed as being at nutrition risk receive nutrition therapy.

Patients could include malnourished children, patients unable to take normal meals for whatever reason, e.g. inability to swallow, specific disease processes. This could include the provision of nutritional supplements or the provision of full parenteral nutrition.

This criterion and those that follow apply only to nutrition therapy and do not include special diets.

*Compliance of all these criteria will be verified during the **patient record audit.***

14.7.1.5 A collaborative process is used to plan, deliver and monitor nutrition therapy.

*This should include the involvement of a dietician if available. Compliance will be verified during the **patient record audit.***

Linked criteria:
1.3.2.1
21.3.1.1

14.7.1.6 Nutrition therapy provided, either oral or intravenous, is written in the patient's record.

14.7.1.7 Response to nutrition therapy is monitored and recorded.

This may take the form of weight/mass checks, laboratory tests for protein and/or lipid levels etc.

14.8 Patient and Family Education

14.8.1 Education supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education. Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible. Education is focused on the specific knowledge and skills that the patient and his or her family will need to participate and make decisions on how to contionue with care continue care at home. Variables like educational literacy, beliefs and limitations are taken into account.

Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record. Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administration, they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient. Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.

Community organisations that support health promotion and disease prevention education are identified and, when possible, on-going relationships are established.

*Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.*

14.8.1 Criteria

14.8.1.1 Patients and families indicate that they have been informed about their diagnosis.

14.8.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
5.3.1.2

14.8.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use, etc.

Linked criterion:
14.7.1.3

14.8.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

14.9 Continuity of Care

14.9.1 *The organisation designs and carries out processes to provide continuity of patient care services within the organisation and Coordination among health professionals.*

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providersmay be involved in providing care. Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

14.9.1 Criteria

14.9.1.1 Policies and procedures that guide the movement of patients within the organisation are implemented.

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

14.9.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

14.9.1.3 Continuity and Coordination are evident throughout all phases of patient care.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

14.9.1.4 The record of the patient accompanies the patient when transferred within the organisation.

14.9.2 There is a process known to staff to appropriately refer patients for specialized consultation/ investigation at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialized treatment that the referring organisation may be unable to provide. The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

14.9.2 Criteria

14.9.2.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
1.2.5.4

14.9.2.2 A copy of the referral note is available in the patient record.

14.9.2.3 Follow-up care, based on the findings of investigations/consultations performed outside the organisation are noted in the patient record.

14.9.3 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation at another health facility (the patient returns to the referring facility after the consultation) and/or treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the

patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

14.9.3 Criteria

14.9.3.1 There is a documented process for transferring patients to other organisations.

Linked criteria:
1.2.5.4
14.9.3.6

14.9.3.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

14.9.3.3 The process for transferring the patient considers transportation needs.

14.9.3.4 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

14.9.3.5 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

14.9.3.6 A copy of the transfer summary is available in the patient record.

Critical criterion

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
14.9.3.1

14.9.2.7 The health organisation agreeing to receive the patient is noted in the patient's record.

14.9.4 There is an organised process to appropriately discharge patients.

Standard Intent

The organisation begins to plan for the patients' continuing needs as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits.

Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.
The summary contains at least;

a) the reason for admission
b) the diagnosis of main and significant illnesses
c) the results of investigations that will influence further management
d) all procedures performed
e) the patient's condition at discharge
f) discharge medications
g) follow-up arrangements.

14.9.4 Criteria

14.9.4.1 There is a documented process to appropriately discharge patients.

Linked criteria:
1.2.5.4, 1.3.2.1

14.9.3.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

Compliance for this criterion and the following will be verified through ***patient record audits****,*

14.9.3.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow-up instructions may be provided to the patient by the doctor or by the nurse, following instructions from the doctor.

The instructions should include medications, wound care, possible complications, return for follow-up care, when and where to obtain urgent care, etc.

14.9.3.4 A discharge summary, which includes at least items a) to g) in the intent statement, is written, by the medical practitioner when each patient is discharged.

This criterion and the next apply to the discharge summary completed by the medical practitioner and not to the nurses' discharge note. Where a discharge summary has only been partially completed i.e. does not include all items a) to g) it will be scored PC. A nurse's discharge note is not acceptable and is scored NC.

14.9.3.5 Each record contains a copy of the discharge summary.

14.10 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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/co-ordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.
Quality monitoring could include:

a) patient assessment
b) mortality and morbidity rates
c) surgical procedures carried out
d) the use of antibiotics and other medications and medication errors
e) the use of anaesthesia
f) the use of blood and blood products
g) patient and family expectations and satisfaction.

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.

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

Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

14.10.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

14.10.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings or specialised investigative studies, e.g. APACHE III. An indicator, in this context is a measure used to determine improvements in clinical care over time.

Examples:
1. the number of bed sores/post-operative wound infections
2. nosocomial infection rates (barrier nursing/hand washing)
3. the percentage of partograms correctly completed and
4. the caesarean section rate.

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

14.10.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level. Where the documentation (patient record) audit is a hospital-wide multidisciplinary process, that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

14.11 Patient Rights

14.11.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

14.11.1 Criteria

14.11.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against legislation, where applicable. Implementation the policies will be evaluated during the patient record audits and patient interviews as well as by observation

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

14.11.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

14.11.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

14.12 Prevention and Control of Infection

14.12.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

14.12.1 Criteria

14.12.1.1 The department identifies the procedures and processes associated with the risk of infection~~,~~ and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in the~~ir~~ department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

14.12.1.2 Infection control processes includes prevention of the spread of respiratory tract infections.

14.12.1.3 Infection control processes includes prevention of the spread of urinary tract infections.

14.12.1.4 Infection control processes includes prevention of the spread of infection through intravascular invasive devices.

14.12.1.5 Infection control processes includes prevention of the spread of infection through surgical wounds.

14.13 Risk Management

14.13.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

14.13.1 Criteria

14.13.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial, and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

14.13.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
14.6.2.5 and 6

14.13.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

14.13.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

14.13.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 15 PSYCHIATRIC CARE

OVERVIEW OF PSYCHIATRIC CARE

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and co-ordination. For patients requiring psychiatric care special needs apply. It has been shown that the best results are achieved where the patient is treated by a multidisciplinary team, using the least restrictive environment.

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up. For individuals in forensic settings, decisions based on court orders must be addressed. The initial assessment and decision concerning services required or to be provided may be performed by a different organisation than the one providing the comprehensive assessment and treatment.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, law and regulation, an individual's particular skills, knowledge and experience, and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, curative or rehabilitative and may include the use of anaesthesia (during electro-convulsive therapy), medication, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Non-clinical constraints affect admission, treatment and discharge decisions in organisations providing forensic services. Such an organisation often must accept court-ordered admissions and has limited ability to select the type of individuals it will serve. In addition, such organisations often cannot limit their admissions to individuals requiring the level of care and services they offer. That is, such organisations are also required by the courts and the forensic system to admit, to 24-hour care, a significant number of individuals who may not require mental health services or who could be adequately served on an outpatient or partial-hospitalisation basis if security were not a concern. Furthermore, such an organisation often cannot give individuals increasing freedom (for example community visits) as part of their treatment programme or discharge them without a court order.

Continuity of care:
From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation.

Processes for continuity and Coordination of care among medical practitioners, nurses and other health service providersmust be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure Coordination of care.

Standards

15.1 Coordination of Patient Care

15.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

15.1.1. Criteria

15.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers i.e. medical practitioners and nurses.Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists.

It is important to assess the availability of medical practitioners, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

15.1.1.2 The individuals responsible for the patient's care are qualified.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of staff, related to the type of patients, acuity levels, bed occupancy levels.

The level of qualifications required would be dependent on the category of the relevant hospital. For example, a small district level hospital could probably utilise a qualified psychiatric trained registered nurse with supervisory or management experience, while a referral level hospital would utilise a registered nurse with advanced nursing as well as management qualifications.

Proof of current registration with the relevant authority, where applicable, must be available

Linked criteria:
2.2.1.1, 2.2.1.4, 2.5.1.1
15.4.1.2, 15.6.1.1, 15.6.2.1

15.1.1.3 The individuals responsible for the patient's care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times.
Patient interviews *will reveal whether staff introduced themselves to patients.*

Linked criterion:
15.3.3.3

15.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

15.1.2 Criteria

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

Root criterion

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 relevant criteria in this document.*

Linked criterion
1.3.2.4:

15.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Root criterion
Clinical professionals (medical practitioners, nurses, professions allied to medicine, social workers, etc.) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record.

Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health care professionals are not available because they are kept separately in another location, this criterion will be scored PC.

15.1.2.3 Information exchanged includes a summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.***
If the notes of medical practitioners and other health care professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criterion:
15.5.1.1

15.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

15.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide and record their activities related to patient care, signatures and designations must be available and the authors must be identifiable.

Methods of verifying signatures and designations could include:
- Names and designations printed below signatures
- Stamps indicating names and designations and/or
- Specimen signature lists in the patient records or in the relevant department.

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and

initials used in patient records. If signature lists are used these need to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

15.1.2.6 The date of each patient record entry can be identified.

Records must follow a chronological order to allow for a logical flow of information. Compliance will be verified during the ***patient record audit.***

15.1.2.7 The time of each patient record entry can be identified.

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

15.2 Facilities and Equipment

15.2.1 Adequate resources are available for the provision of safe care to patients in the ward.

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms, and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard expressly for this purpose. There are adequate toilet and bathing facilities for the number of patients in the ward, as determined by national legislation.

There is adequate lighting and ventilation.

Nurse call systems, which are connected to the emergency power supply, are available at bedsides and in bathrooms and toilets.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily. Each ward is provided with a socket outlet that is connected to the emergency power supply.

A resuscitation trolley is available at the point of need within 1 minute. In addition there is access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any patient collapsing. Resuscitation equipment includes at least:

- a defibrillator with adult paddles / pads (and paediatric paddles / pads where applicable)
- an ECG monitor
- a CPR board (if required)
- suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- a bag-mask manual ventilator
- a range of endotracheal tubes and 2 laryngoscopes, with a range of straight

and curved blades, spare batteries, spare globes where applicable
- an introducer /stylet for endotracheal intubation
- a syringe to inflate ETT cuff
- oropharyngeal tubes
- equipment to perform an emergency cricothyroidotomy - (needle and surgical)
- appropriate facilities for intravenous therapy and drug administration (including paediatric sizes where applicable)
- drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
- plasma expanders.

15.2.1 Creteria

15.2.1.1 Patient and staff accommodation in the service is adequate to meet patient care needs.

Root criterion.
There should be adequate office space for staff, clean and hygienic sluice rooms, treatment and dressing rooms, demonstration rooms, adequate and tidy linen and equipment storage facilities, lighting and ventilation, adequate and hygienic bathroom and toilet facilities for the number of patients, as well as a the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6
29.2.1.1

15.2.1.2 Oxygen and vacuum supplies meet the needs of patients for care.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. This includes the availability of a sufficient number of functional flow-meters.

Any evidence of infection control deficiencies e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9 (Prevention and Control of Infections).

Linked criteria:
29.2.2.1, 29.2.3.2

15.2.1.3 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture.

Linked criterion:
31.2.1.5

15.2.1.4 Resuscitation equipment is available in accordance with the policies of the organisation.

Critical criterion

Must include at least the items mentioned in the Intent statement and according to National requirements.

Resuscitation equipment and documented evidence of the checking thereof in the unit, according to the organisation's resuscitation policy must be available. Checking must include the identification of expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or *automated external defibrillator* (AED) within 3 minutes of any patient collapsing.

Linked criterion:
30.2.1.2

15.2.1.5 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

15.2.1.6 Each patient has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess effective response from ***patient interviews*** *and patient complaints.*

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criteria:
29.2.1.2

15.2.1.7 Electricity and water is available in accordance with the policies of the organisation.

Ward/unit personnel need to have knowledge of routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

15.3 Clinical Practice Guidelines

15.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means to improve quality and assist practitioners and patients in making clinical decisions. Guidelines are found in the

literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisation leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisation resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

15.3.1 Criteria

15.3.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

Guidelines/protocols relevant to the patients and services are assessed in each department according to the disease profiles of the patients admitted.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.
In the absence of guidelines this criterion will be scored NC.

Linked criterion:
1.3.2.2

15.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available that the management of high cost, high risk, high volume and problem prone conditions are considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criterion:
8.2.1.4

15.3.1.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

15.4 Assessment of Patients

15.4.1 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters a ward the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations. These findings are used throughout the care process to evaluate patient progress and understand the need for re-assessment. It is essential that assessments are documented well and can be easily retrieved from the patient's record.

The health organisation determines the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

15.4.1 Criteria

15.4.1.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care.

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during the assessment of patients. The provision of specifically designed assessment forms for each relevant discipline is considered as evidence of the implementation of such a policy. Where the required information, according to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

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

Linked criteria:
1.3.2.1
15.1.2.2, 15.4.2.1, 15.4.3.1

15.4.1.2 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of notes made by the doctor in the patient record, or other relevant clinical staff other than nursing staff will affect the outcome of the audit process. The signature and designation of the individual making entries into the patients' records must be identifiable.*

Linked criterion:

15.1.1.2

15.4.1.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation makes use of standardised formats of clinical assessment forms for specific use by different disciplines. The absence of medical notes by relevant clinical personnel in the patient record will affect the outcome of the audit process.

Refer to criterion 15.4.1.1

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

15.4.1.4 Policies and procedures ensure that assessments are performed within appropriate time frames and that they are adequately documented in the patients' records.

Time frames for the assessment of patients need to be established for each discipline e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done/completed. These time frames need to be stated in the policy framework.

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

15.4.2 Each patient has an initial assessment that complies with current policies, procedures and guidelines.

Standard Intent

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those in pain, patients suspected of drug and/or alcohol dependency, and victims of abuse and neglect. The assessment process is modified in accordance with the national guidelines..

A psychosocial assessment of the child or adolescent receiving inpatient, residential, partial-hospitalisation, continuing outpatient, home care or case-management services and his or her family includes an evaluation of the effect of the family or guardian on the condition of the individual served and the effect of the condition on the family or guardian. As part of the assessment process, the organisation identifies the adult(s) who has legal custody e.g. in the case of divorced parents. This may

prevent conflicts during care or discharge planning that can be detrimental to the adolescent.

In terms of the care of the intellectually disabled persons, family involvement must be encouraged. For many individuals, participation by family members will be a significant factor in achieving goals. The importance of participation by family in treatment planning is related to age or disability factors. Family members generally need to participate in the treatment of children and adolescents.

The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge is initiated during the initial assessment process.

When the medical/psychological assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

15.4.2 Criteria

15.4.2.1 Each patient admitted has an initial assessment that meets organisation policy.

Root criterion.

Documented evidence in the form of a detailed policy and procedure or guideline is provided. To ensure Coordination of patient care, all members of the team should be included in the formulation of this policy framework, especially doctors and nurses.

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

Linked criteria:
15.4.1.1, 15.4.3.1

15.4.2.2 The initial assessment includes health history.

Compliance is measured in the relevant areas in the patient's records. This criterion will be scored PC if medical practitioners' notes or notes by relevant clinical personnel are not available.

Compliance will be verified during the ***patient record audit.*** *This applies to all the following criteria relevant to this standard.*

15.4.2.3 The initial assessment includes physical examination.

If medical practitioner notes are not available this will be scored NC.

Vital sign measurement is not considered a physical examination.

The only exceptions are where physical assessments are undertaken by nurses with special training i.e. SEs 13, 14 and 24

15.4.2.4 The initial assessment includes functional examination, where applicable.

15.4.2.5 The initial assessment includes social and economic assessment, where applicable.

15.4.2.6 The initial assessment includes psychiatric assessment.

15.4.2.7 The initial assessment includes cultural assessment, where applicable.

15.4.2.8 The initial assessment results in an initial diagnosis.

15.4.2.9 The initial assessment results in the identification of the patient's medical, nursing or other therapeutic needs.

Linked criterion:
7.2.5.2

15.4.3 Health professionals responsible for patient care collaborate to analyse and integrate assessment information.

Standard Intent

A patient benefits most when the personnel responsible for the patient work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established, and care decisions are made.

15.4.3 Criteria

15.4.3.1 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

There should be evidence that all clinical professionals dealing with the patient have contributed to the patient's record,

Compliance of this criterion and the following will be verified during the ***patient record audit.*** *If notes by a relevant clinical professional are not found, the criterion will be scored PC.*

Linked criteria:
15.4.1.1, 15.4.2.1

15.4.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

15.4.3.3 Patient needs are prioritised on the basis of assessment results.

15.4.3.4 The patient and/or the family participate in the decisions regarding the priority needs to be met.

*Compliance will be assessed from **patient interviews and/or** the **patient record audits**.*

15.5 Patient Care

15.5.1 The care provided to each patient is planned and written in the patient's record.

Standard Intent

A single, integrated plan is preferable to a separate care plan recorded by each health professional.

Collaborative care and treatment team meetings or similar patient discussions are recorded.

Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.

The organisation decides:

- which orders must be written rather than verbal
- who is permitted to write orders
- where orders are to be located in the patient's record.

The method used must respect the confidentiality of patient care information.

15.5.1 Criteria

15.5.1.1 The planned care is provided and noted in the patient's record.

Root criterion.

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

Linked criteria:
15.1.2.3

15.5.1.2 All procedures and diagnostic tests ordered and performed are written into the patient's record.

The term "written" here implies documented evidence. Such evidence may include nursing and medical practitioners' notes, as well as printed reports, which are filed in the patient record.

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

15.5.1.3 The results of procedures and diagnostic tests performed are available in the patient's record.

This criterion will be scored PC if the results are not initialled by the medical practitioner, the treatment plan does not indicate action taken, or the nursing notes do not indicate that the doctor was informed.

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

15.5.1.4 Re-assessments are documented in the patient's record.

15.5.1.5 The patient's plan of care is modified when the patient's needs change.

15.5.2 Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

Standard Intent

Some patients are considered "high-risk" because of their age, condition or the critical nature of their needs. Psychiatric patients, children and the elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Policies and procedures are important. They help the personnel understand these patients and services, and respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training staff in their implementation.

The special facilities and safety measures required by children need to be specified. It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required for the care team to work effectively
- special consent considerations
- monitoring requirements
- special qualifications or skills of the personnel involved in the care process
- the resuscitation equipment available and how to use it, including equipment for children.

Clinical guidelines should be incorporated in the process because there are several criteria requiring guidelines to be used. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high-risk patients and procedures, e.g.:

a) the care of emergency patients
b) the care of patients with communicable diseases
c) the care of immuno-suppressed patients
d) the use of restraint and the care of patients in restraint

e) the care of frail, dependent elderly patients
f) the care of young, dependent children
g) the use of seclusion and the care of patients in seclusion
h) the management of patients with eating disorders
i) the management of the detoxification stage of treatment
j) the management of patients who may be a danger to themselves or others
k) the administration of electro-convulsive therapy and care of patients following ECT
l) the management of the violent patient
m) the searching of patients, visitors, parcels and staff for harmful objects, substances and unwanted materials.

15.5.2 Criteria

15.5.2.1 Policies and procedures for identified high-risk patients and procedures, which include at least items a) to m) in the intent statement above, are implemented.

The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training personnel in their implementation.

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

Linked criteria:
1.3.2.1
7.2.5.1
9.2.1.8

15.5.2.2 The personnel are trained and use the policies and procedures to guide care.

*Where policies and procedures refer to patient care the same rule as 15.4.2.1 is applied, i.e. compliance will be measured against the relevant areas in the patients' records during the **record audit process.***

By implication, if the policies are implemented, personnel can be considered to have been trained and this criterion will be scored accordingly. This "training" could take the form of formal in-service training, introduction at orientation to policies, discussions at departmental meetings, case studies, etc.

15.5.3 Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Standard Intent

This section deals with the process of obtaining informed consent from patient and does NOT refer to providing health education in general, which is dealt with in standard 15.8.

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests,

procedures and treatments require consent and how they can give consent, for example verbally, by signing a consent form, or through some other mechanism. Patients form. Patients and families understand who may, in addition to the patient, give consent.

Designated personnel are trained to inform patients and to obtain and document patient consent e.g. a medical practitioner for the administration of ECT, or a nurse for HIV testing. These staff members clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications
- consideration of other options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written informed consent. Leaders document the processes for the obtaining of informed consent.

The consent process always concludes with the patient or his/her proxy signing the consent form, or the documentation of the patient's or his/her proxy's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledged full understanding of the information. The patient's medical practitioner or other qualified individual provides the necessary information and the name of this person appears on the consent form.

15.5.3 Criteria

15.5.3.1 There is a documented process for the obtaining of informed consent.

Root criterion

*This section refers to all instances where patients give informed consent and compliance will be verified during the patient **record audit**. If consent was not required for the patient records audited, this whole standard becomes NA.*

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 15.5.3.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC because the process has not been implemented.

Linked criterion:
5.6.1.1

15.5.3.2 Patients/proxies are informed about their condition, and the proposed treatment.

15.5.3.3 Patients/proxies know the identity of the medical practitioner or other professional practitioner responsible for their care.

Linked criterion:
15.1.1.3

15.5.3.4 The information provided is recorded, with the record of the patient/proxy having provided written or verbal consent.

Critical criterion

*Compliance ~~is~~ will be verified during the **patient record audit.***
If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information as indicated in the relevant criteria abov and this criterion, including those above, are scored compliant.

Where the form is not completed according to policy this criterion will be scored PC or NC, depending on the average results of the record audit. In that case the relevant criteria above will be scored the same.

Linked criterion:
5.6.1.1

15.5.4 Each patient participates in a structured treatment plan.

Standard Intent

Each patient has psychotherapeutic interviews with an appropriately qualified person to meet his/her needs.

There is a structured therapeutic environment, which allows for group therapy, occupational therapy, music or art therapy as required by individual patients.

15.5.4 Criteria

*Compliance with this standard will be verified during the **patient record audit.***

15.5.4.2 There is evidence of regular psychotherapeutic interviews as indicated by the programme and individual patient's needs.

15.5.4.3 There is a range of therapeutic activities available, according to the identified needs of the patient.

15.5.4.4 There is documented participation of the patient with his or her family or significant other(s) in group therapy, as appropriate.

15.5.4.5 The patient has the least restrictive environment possible, with any restrictions placed upon him/her written into the treatment plan.

15.5.5 Pre- and post-anaesthetic assessments are documented.

Standard Intent

This standard applies to settings where electro-convulsive therapy (ECT) is administered.

The pre-anaesthetic assessment determines if the patient is a good candidate for the planned anaesthesia. The clinical assessment and results of investigations must be available to the medical practitioner performing the ECT. Post-ECT monitoring is appropriate to the patient's condition.

15.5.5 Criteria

15.5.5.1 The patients' initial medical assessment is documented before anaesthesia.

Documented evidence in the form of a detailed policy and procedure or guideline is provided as to who may perform this assessment, i.e. the person responsible for administering the anaesthetic.

Compliance with criteria 15.5.5.1 to 5 will be verified during the ***patient record audit.***

15.5.5.2 Patients have the results of diagnostic tests recorded before anaesthesia.

15.5.5.3 The names of the anaesthetist, the medical practitioner who performs the ECT and other personnel as required by law, are documented.

15.5.5.4 The patient's physiological status is monitored during the immediate post-ECT period.

Critical criterion

Linked criterion:
15.10.1.3

15.5.6 *The organisation implements processes to support the patient in managing pain.*

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and re-assessment
- communicate with, and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs

- educate health service providersin pain assessment and management.

15.5.6 Criteria

15.5.6.1 The assessment process makes provision for patients in pain to be identified.

15.5.6.2 Patients in pain receive care according to pain management guidelines.

There should be evidence that all clinical professionals dealing with the patient's pain management have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment. These records will also be evaluated.

Compliance will be verified during the ***patient record audit.***
Linked criterion:
1.3.2.1

15.5.6.3 Patients and families are educated about pain and pain management.

Compliance will be verified during the ***patient record audit and patient interviews.***

15.5.6.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.4

15.5.7 *The organisation develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful, compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all personnel are made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the organisation includes:

a) providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) sensitively addressing issues such as autopsy and organ donation
c) involving the patient and family in all aspects of care
d) responding to the psychological, emotional, spiritual and cultural concerns of the patient and family.

15.5.7 Criteria

15.5.7.1 Policies and procedures regarding end-of-life care, at least including elements a) to d) in the intent statement, are implemented.

*Evidence can be sought in **patient records** and by observation of the care process. Another example would be the manner in which the policy on withholding resuscitation is applied.*

Linked criteria:
1.3.2.1
5.4.2.1

15.5.7.2 The patient and the family/significant other(s) are involved in care decisions.

The decision should be the patient's in terms of whom they consider the most important individual to support them at this time.

15.5.7.3 Pain and primary or secondary symptoms are managed.

15.5.7.4 Interventions address patient and family religious and cultural concerns.

15.6 Medication

15.6.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

15.6.1 Criteria

15.6.1.1 Policies and procedures that guide the safe prescribing, ordering, dispensing and administration of medications are implemented.

Root criterion

These policies need to be developed by all the role-players i.e. medical practitioners, medical practitioners, nursing staff and pharmacists.
National regulations related to medication prescription and administration will apply.

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

Linked criteria:
1.3.2.1
15.1.1.2
21.1.2.1, 21.3.1.1

15.6.1.2 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
15.6.2.3
21.3.1.1

15.6.1.3 Only those permitted by the organisation and by relevant law and regulation prescribe medication.

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

Linked criteria:
15.1.1.2

15.6.1.4 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the patient's medical practitioner and are noted in the patient's record.

Implementation of the organisation policy is required. This includes traditional, over-the-counter and homeopathic medicines.

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

Linked criterion:
21.3.1.1

15.6.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, medical practitioner, nurse and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed and to evaluate the patient for adverse effects.

The organisation follows national requirements for the reporting of adverse effects. Doctors, nurses, and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

15.6.2 Criteria

15.6.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criteria:
15.1.1.2

15.6.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

15.6.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
15.6.1.2
21.3.1.1

15.6.2.4 Health professionals monitor medication effects on patients collaboratively.

Patient record audits *should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the medical practitioner.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional information may be required. For example, plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

15.6.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

An ***adverse drug reaction*** *(****ADR****) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.*

Compliance is verified during the ***patient record audit.***
Evidence will be sought of documentation reporting the reaction to the physician and the pharmacist.

Linked criteria:
7.1.1.7
15.13.1.2
21.6.1.1, 21.9.1.2

15.6.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for the recording of medication errors. These include errors in relation to prescribing, dispensing and administration of medication.

Linked criteria:
7.1.1.7
15.13.1.2
21.6.1.1, 21.9.1.2

15.6.2.7 The medications prescribed for and administered to each patient are recorded.

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

15.6.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

15.6.2 Criteria

15.6.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised staff.

All medication storage areas (trolleys, cupboards, rooms, refrigerators etc.) are examined for compliance.

An unlocked refrigerator will only be accepted, if it is in a locked room with access limited to relevant personnel only.

An unlocked refrigerator in an unlocked room will be scored as NC.

15.6.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised staff have the keys.

The laws and regulations or organisational policy will determine the nature of these medications.

Linked criterion:
21.5.1.11

15.6.3.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion
Compliance needs to be measured against the medicine control regulations.
Control measures generally include the keeping of medicine registers for these items.

Linked criterion:
21.5.1.11

15.6.3.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion

National regulations will apply, but must include at least the following:
- *name of ward and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number and*

- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criteria:
21.4.1.4

15.6.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

Linked criterion:
21.5.1.7

15.6.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criteria:
21.5.1.9

15.6.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication.

Linked criterion:
21.5.1.9

15.6.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion

Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

15.6.3.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

15.7 Food and Nutrition Therapy

15.7.1 Food and nutrition therapy appropriate for the patient and consistent with his or her clinical care is regularly available.

Standard Intent

A qualified caregiver orders appropriate food or other nutrients. The patient participates in planning and selecting foods, and the patient's family may, when appropriate, participate in providing food. They are educated as to which foods are contraindicated, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status. The nutritional status of the patients is monitored.

15.7.1 Criteria

15.7.1.1 Food, appropriate to the patient, is regularly available.

Compliance is verified from interviews with personnel and patients, especially regarding times of meals and the availability of special diets.
Menus and meal times will be checked.

Linked criterion:
26.4.1.3

15.7.1.2 An order for food, based on the patients' nutritional status and needs, is recorded in the patient's file.

*Compliance will be verified during the **patient record audit**, especially as it relates to the patient's assessment, the care plan and the identification of special diet requirements. Prescribed diets are ordered and delivered to the patient.*

15.7.1.3 When families provide food, they are educated about the patient's diet limitations.

*Compliance will be verified during the **patient record audit***

Linked criteria:
15.8.1.3

15.7.1.4 Patients assessed as being at nutrition risk receive nutrition therapy.

Patients could include malnourished children, patients unable to take normal meals for whatever reason e.g. unable to swallow, specific disease processes. This could include the provision of nutritional supplements or the provision of full parenteral nutrition.

This criterion and those that follow apply only to nutrition therapy and do not include special diets.

*Compliance of all these criteria will be verified during the **patient record audit.***

15.7.1.5 A collaborative process is used to plan, deliver and monitor nutrition therapy.

*This should include the involvement of a dietician if available. Compliance will be verified during the **patient record audit.***

Linked criteria:
1.3.2.1
21.3.1.1

15.7.1.6 Nutrition therapy provided, either oral or intravenous, is written in the patient's record.

15.7.1.7 Response to nutrition therapy is monitored and recorded.

This may take the form of weight/mass checks, laboratory tests for protein and/or lipid levels etc.

15.8 Patient and Family Education

15.8.1 Education supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to participate and make decisions, on how to continue with care at home..

Variables like educational literacy, beliefs and limitations are taken into account.
Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Community organisations that support health promotion and disease prevention education are identified and, when possible, on-going relationships are established.

*Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.*

15.8.1 Criteria

15.8.1.1 Patients and families indicate that they have been informed about their diagnosis.

15.8.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
5.3.1.2

15.8.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use, etc.

Linked criterion:
15.7.1.3

15.8.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

15.9 Continuity of Care

15.9.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and Coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providersmay be involved in providing care. Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

15.9.1 Criteria

15.9.1.1 Policies and procedures that guide the movement of patients within the organisation are implemented.

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units. Please take note that a transfer to theatre (for ECT) is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

15.9.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

15.9.1.3 Continuity and Coordination are evident throughout all phases of patient care.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

15.9.1.4 The record of the patient accompanies the patient when transferred within the organisation.

15.9.1.5 Documentation regarding the transfer of a patient from the forensic service to another service within the organisation meets legal requirements.

15.9.2 There is a process known to personnel to appropriately refer patients for specialised consultation/investigations at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialised treatment that the referring organisation may be unable to provide. The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

15.9.2 Criteria

15.9.1.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
1.2.5.4

15.9.2.2 A copy of the referral note is available in the patient record.

15.9.2.3 Follow-up care based on the findings of investigations/consultations performed outside the organisation are noted in the patient record.

15.9.3 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation at another health facility and/or treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient.

Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

15.9.3 Criteria

15.9.3.1 There is a documented process for transferring patients to other organisations.

Linked criteria:
1.2.5.4
15.9.3.6

15.9.3.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

15.9.3.3 The process for transferring the patient considers transportation needs.

15.9.3.4 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

15.9.3.5 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

15.9.3.6 A copy of the transfer summary is available in the patient record.

Critical criterion

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
15.9.3.1

15.9.3.7 The health organisation agreeing to receive the patient, is noted in the patient's record.

15.9.4 There is an organised process to appropriately discharge patients.

Standard Intent

The organisation begins to plan for the patients' continuing needs as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

The summary contains at least

a) the reason for admission
b) the diagnosis of main and significant illnesses
c) the results of investigations that will influence further management
d) all procedures performed
e) the patient's condition at discharge
f) discharge medications
g) follow-up arrangements.

15.9.4 Criteria

15.9.1.2 There is a documented process to appropriately discharge patients.

Root criterion
Linked criteria:
1.2.5.4, 1.3.2.1

15.9.4.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

Compliance for this criterion and the following will be verified through ***patient record audits****.*

15.9.4.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow-up instructions may be provided to the patient by the medical practitioner or by the nurse, following instructions from the doctor.

The instructions should include medications, possible complications, return for follow-up care, when and where to obtain urgent care, etc.

15.9.4.4 A discharge summary, which includes at least items a) to g) in the intent statement, is written, by the medical practitioner, at discharge of each patient.

This criterion and the next apply to the discharge summary completed by the medical practitioner and not to the nurses' discharge note. Where a discharge summary has only been partially completed i.e. does not include all items a) to g) it will be scored PC. A nurse's discharge note is not acceptable and is scored NC.

15.9.4.5 Each record contains a copy of the discharge summary.

15.10 Special Psychiatric Services

15.10.1 Where electro-convulsive therapy is provided, the service is managed and staffed to ensure patient safety.

Standard Intent

Electro-convulsive (ECT) therapy carries high risk. The collaboration between personnel in the therapy unit, health and safety representatives and those responsible for the supply and maintenance of equipment is essential.

Electro-convulsive therapy personnel work with organisation leaders to ensure adequate and suitable management processes and staffing of the unit.

The qualifications of those persons who administer anaesthesia in the hospital are documented in accordance with current professional society standards.

15.10.1 Criteria

15.10.1.1. A senior medical practitioner who is suitably qualified and experienced is in charge of the electro-convulsive therapy service.

15.10.1.2 The design of the ECT treatment area provides space for the reception, anaesthesia, treatment, recovery and observation of patients.

Electro-convulsive therapy is a form of somatic treatment that uses electricity to evoke a convulsive response. Electro-convulsive therapy is a non-invasive procedure, which is carried out under general anaesthesia. A full-scale operating theatre is not used and everything used, except for injection equipment, is "surgically clean" rather than "sterile.

There are areas for the disposal and collection of used equipment and waste, including

contaminated waste and sharps. Safe and adequate storage space for pharmaceutical and surgical supplies is available, including separate lockable cupboards for scheduled substances and other scheduled medicines and for inflammables.

Personnel are provided with office facilities or a day station, a restroom, washrooms and toilets. This may be a self-contained unit or a unit/room attached to a ward.

15.10.1.3 Policies and procedures relating to the activities in the ECT unit are implemented.

Policies and procedures are necessary to guide the administration of the ECT service to ensure the smooth operation of the service, and to ensure that personnel act swiftly and in a co-ordinated manner in an emergency.

Policies and procedures should at least include:
a) qualifications of persons who administer anaesthetics
b) duties of the ECT area's nursing staff
c) patient identification
d) checking of consent documents
e) notification of biohazards (e.g. electrical hazards)
f) patient positioning
g) drug control
h) post-procedure monitoring of the patient
i) cleaning of equipment and the treatment area.

Linked criterion:
15.5.5.4

15.10.1.4 There is documented evidence that the patient has consented to the procedure.

Because convulsive therapies raise societal and individual rights concerns, fully documented and fully informed consent is essential to protect individuals served, personnel and the organisation. Professional guidelines must be available to personnel and closely followed.

(See standard 15.5.3)

15.10.1.5 Anaesthesia is administered only by qualified anaesthetists.

Critical criterion

Anaesthesia risks are significantly reduced when appropriate and well-functioning equipment is used to administer anaesthesia and monitor the patient. Adequate supplies and medication are also available for planned use and emergency situations. Each organisation understands the required or recommended equipment, supplies and medications necessary to provide anaesthesia services to its patient population. Recommendations on equipment, supplies and medication can come from a government agency, national or international anaesthesia professionals or other authoritative sources. There is an equipment maintenance programme.

Linked criterion:
17.1.2.4

15.10.1.6 Emergency resuscitation equipment is available in the ECT unit according to organisation policy.

Critical criterion

See intent statement of standard 15.2.1

15.10.2 Where forensic services are provided, they comply with country-specific legislation.

15.10.2 Criteria

15.10.2.1 Policies and procedures that guide the care of forensic patients and the provision of forensic services are implemented.

Policies and procedures should address, at least:
a) access control into the forensic unit
b) access control within the forensic unit
c) control of keys
d) patient absconding from the forensic unit
e) management of the violent patient
f) management of mass violence in the unit
g) control of photographs or other artistic reproductions of patient
h) transfer of patients from the forensic service.

15.10.2.2 Security or correctional personnel are educated/trained about their responsibilities in relation to assisting with the management of patients.

In forensic units security or correctional staff may be employed to assist with the management of patients. Their roles and responsibilities must be clearly defined in writing and should include:
a) the organisation's channels of clinical, security and administrative communication
b) the distinction between administrative and clinical seclusion and/or restraint
c) their response to and reporting of unexpected or unusual clinical events.

Evidence will be sought from training records and ***personnel interviews.***

Linked criterion:
15.14.1.3

15.10.2.3 All seclusion or restraint, whether for clinical or non-clinical purposes, is documented in the patient's record.

Non-clinical constraints can affect admission, treatment and discharge decisions in organisations providing forensic services. When conflict with security and individual needs occur, personnel develop an adapted plan to simulate normalised experiences.

Compliance will be assessed from ***patient record audits.***

15.10.2.4 There are mechanisms designed to facilitate communication and resolve conflict between judicial, correctional, penal, clinical and administrative agencies and those involved in an individual's care.

Legal, correctional and/or administrative decisions affecting an individual's treatment are co-ordinated with clinical decisions related to:
a) use of seclusion and restraint for non-clinical purposes
b) imposition of disciplinary restrictions
c) length of stay
d) restriction of rights
e) plan for discharge and continuing care.

15.11 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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/co-ordinating structures/systems for quality management. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:
a) patient assessment
b) the use of medications and medication errors
c) the use of sedation and/or anaesthesia
d) patient and family expectations and satisfaction.

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
- 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.

A once-off project, for example, the supply of specific equipment, will be scored NC.

Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

15.11.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:
- at least one clinical audit
- participation in documentation (patient record) audits
- participation in the monitoring of near misses, sentinel and adverse events.

Linked criterion:
8.2.2.1

15.11.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, reports on negative incidents, etc.

An indicator, in this context, is a measure used to determine improvements in clinical care over time. Refer to the intent for 15.11.1 for examples.

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

15.11.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level. Where the documentation (patient record) audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criteria:
8.2.1.5

15.12 Patient Rights

15.12.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews

15.12.1 Criteria

15.12.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against legislation, where applicable. The implementation thereof will be evaluated during the auditing of patient records, patient interviews and observation during a walk-about in the department.

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

15.12.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

15.12.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

15.13 Prevention and Control of Infection

15.13.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes on infection prevention and control (Service Element 9).

15.13.1 Criteria

15.13.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

15.13.1.2 Infection control processes includes prevention of the spread of respiratory tract infections.

15.13.1.3 Infection control processes includes prevention of the spread of urinary tract infections.

15.13.1.4 Infection control processes includes prevention of the spread of infection through intravascular invasive devices.

15.13.1.5 Infection control processes includes prevention of the spread of infection through surgical wounds.

15.14 Risk Management

15.14.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational processes on risk management (Service Element 7).

15.14.1 Criteria

15.14.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor related risks, financial, legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

15.14.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation at department level, in the facility's overall system of the monitoring of negative incidents/near misses/adverse events will be evaluated. Analysed data, with responses/remedial action related to departmental incidents are required.

Linked criteria:
7.1.1.7, 7.2.6.4
15.6.2.5 and 6

15.14.1.3 Security measures are in place and implemented to safeguard and protect patients, personnel and visitors.

The department's participation in the facility's overall security plan for staff and visitors will be evaluated.

Linked criteria:
7.4.1.4
15.10.2.2

15.14.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.
Linked criterion:
7.5.1.1

15.14.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collection, storage and disposal of clinical waste.
Linked criterion:
7.7.1.1

SE 16 PAEDIATRIC CARE

OVERVIEW OF PAEDIATRIC CARE STANDARDS

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and co-ordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, law and regulation, an individual's particular skills, knowledge and experience and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medication, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Continuity of Care
From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation.

Processes for continuity and Coordination of care among physicians, nurses and other health service providersmust be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure Coordination of care. Infants and children have very special needs. These needs relate to a bright, stimulating and non-threatening environment.

Standards

16.1 Coordination of Patient Care

16.1.1 During all phases of care there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

16.1.1 Criteria

16.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers, i.e. doctors and nurses.

Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists. It is important to assess the availability of doctors, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

16.1.1.2 The individuals responsible for the patient's care are qualified.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels, bed occupancy levels, etc.

The level of qualifications required would be dependent on the category of the relevant hospital. For example, a qualified general registered nurse with supervisory or management experience could be suitable as a ward manager) in a l district hospital, while a referral level hospital would need a registered nurse with advanced nursing as well as management qualifications.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
16.4.1.2, 16.6.1.1, 16.6.2.1

16.1.1.3 The individuals responsible for the patient's care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times.

***Patient interviews** will reveal whether staff members introduced themselves to patients.*

Linked criterion:
16.5.3.3

16.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the multidisciplinary team. This can be through verbal, written or electronic means according to appropriate policies determined by the organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team and is made available to all relevant caregivers who are authorised to have access to its content.

16.1.2 Criteria

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

Root criterion

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 relevant criteria in this document.*

Linked criterion:
1.3.2.4

16.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (doctors, nurses, professions allied to medicine, social workers, etc) form part of the multidisciplinary /interdisciplinary team and contribute to the patient's record.

Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

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

If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

16.1.2.3 Information exchanged includes summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criterion:
16.5.1.1

16.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

16.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.

Methods of verifying signatures and designations could include:
- *names and designations printed below signatures*
- *stamps indicating names and designations and/or*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

16.1.2.6 The date of each patient record entry can be identified.

*Records must follow a chronological order to allow for a logical flow of information. Compliance will be verified during the **patient record audit.***

10.1.2.7 The time of each patient record entry can be identified.

Patient records include time of arrival at the facility and each time that the patient is assessed by a health professional.

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

16.2 Facilities and Equipment

16.2.1 Adequate resources are available for the provision of safe care to patients in the ward.

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate toilet and bathing facilities for the number of patients in the ward, as determined by national legislation.

There is a temperature-controlled nursery/ward and it has:

- suitable bassinettes
- photo-therapy lights
- a panel for viewing babies
- a designated area for preparing infant feeds
- a fridge for milk feeds only
- facilities allocated for washing utensils used when preparing infant feeds.

There is adequate lighting and ventilation.

Nurse call systems are available at bedsides and in bathrooms and toilets and are connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily. Each ward is provided with a socket outlet that is connected to the emergency power supply.

A resuscitation trolley is available at the point of need within 1 minute. In addition, there is access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any patient collapsing. Resuscitation equipment includes at least:

- a defibrillator with child and infant paddles / pads
- an ECG monitor
- a CPR board (if required)
- suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- a bag-mask manual ventilator
- a range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable
- an introducer /stylet for endotracheal intubation
- a syringe to inflate the ETT cuff
- oropharyngeal tubes
- equipment to perform an emergency cricothyroidotomy – (needle and surgical)
- appropriate facilities for intravenous therapy and drug administration in paediatric sizes
- drugs for cardiac arrest, coma, seizures and states of shock in paediatric doses and
- plasma expanders.

16.2.1 Criteria

16.2.1.1 Patient and staff accommodation and equipment is adequate to meet patient care needs.

Root criterion.

There should be adequate office space for personnel; clean, hygienic sluice rooms, treatment and dressing rooms; demonstration rooms, adequate, tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients, as well as the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6
29.2.1.1

16.2.1.2 Oxygen and vacuum supplies meet the needs of patients for care.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. There must also be enough functional flow meters.

Any evidence of infection control deficiencies, e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9 (Prevention and Control of Infections).

Linked criteria:
29.2.2.1, 29.2.3.2

16.2.1.3 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture.

Linked criterion:
31.2.1.5

16.2.1.4 Resuscitation equipment is available in accordance with the policies of the organisation.

Critical criterion
Must include at least the items mentioned in the Intent statement and according to national requirements.

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or automated external defibrillator *(AED) within 3 minutes of any patient collapsing.*

Linked criterion:
30.2.1.2

16.2.1.5 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

16.2.1.6 Each patient has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess whether responses are effective by interviewing patients/parent/guardian and patient complaints.

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criterion:
29.2.1.2

16.2.1.7 Electricity and water is available in accordance with the policies of the organisation.

Ward/unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

16.2.1.8 There is a dedicated area for preparing infant feeds.

Where there is no dedicated milk kitchen, there is a designated area for preparing infant feeds.

Where feeds are prepared for a 24 hour period, suitable refrigeration and feed warming methods are available.

Protective clothing is available and the personnel maintain good infection control practices.

This criterion cannot be marked NA just because the hospital is considered a "Baby Friendly" facility.

16.3 Clinical Practice Guidelines

16.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits.

This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

16.3.1 Criteria

16.3.1.1 Clinical practice guidelines relevant to the patients and services of the organisation are used to guide patient care processes.

Guidelines/protocols relevant to the patients and services are assessed in each department according to the disease profiles of the patients admitted.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

In the absence of guidelines, this criterion will be scored NC.

Linked criterion:
1.3.2.2

16.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criterion:
8.2.1.4

16.3.1.3 Guidelines are reviewed and adapted on a regular basis after implementation.

Linked criterion:
1.3.2.2

16.4 Assessment of Patients

16.4.1 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters a ward or department, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations. These findings are used throughout the care process to evaluate patient progress and understand the need for reassessment. It is essential that assessments are documented well and can be easily retrieved from the patient's record.

The health organisation determines the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

16.4.1 Criteria

16.4.1.1 The organisation implements policies and procedures for assessing patients on admission and during ongoing care.

Root criterion

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed

assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy. Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

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

Linked criteria:
1.3.2.1
16.1.2.2, 16.4.2.1, 16.4.3.1

16.4.1.2 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of notes made in the patient record by the doctors, nurses, or relevant clinical personnel will affect the outcome of the audit process. The signature and designation of the individual making entries into the patients' records must be identifiable.*

Linked criterion:
16.1.1.2

16.4.1.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline.

The absence of medical notes by relevant clinical personnel, in the patient record will affect the outcome of the audit process. Refer to criterion 16.4.1.1

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

16.4.1.4 Policies and procedures ensure that assessments are performed within appropriate time frames and that they are adequately documented in the patients' records.

Time frames for the assessment of patients need to be established for each discipline, e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

16.4.2 Each patient has an initial assessment that complies with current policies, procedures and guidelines.

Standard Intent

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Planning for discharge is initiated during

the initial assessment process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment, e.g. very young patients, the frail, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process is modified in accordance with national guidelines and protocols. The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

When the medical assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

16.4.2 Criteria

16.4.2.1 Each patient admitted has an initial assessment that meets organisation policy.

Root criterion.

Documented evidence in the form of a detailed policy and procedure or guideline is provided. To ensure Coordination of patient care, all members of the team should be included in the formulation of this policy framework, especially doctors and nurses.

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

Linked criteria:
16.4.1.1, 16.4.3.1

16.4.2.2 The initial assessment includes health history.

Compliance is measured in the relevant areas in the patient's records. This criterion will be scored PC if doctors' notes or notes by relevant clinical personnel are not available.

Compliance will be verified during the ***patient record audit.*** *This applies to all the following criteria relevant to this standard.*

16.4.2.3 The initial assessment includes physical examination.

If medical practitioner notes are not available this will be scored NC.

Vital sign measurement only is not considered a physical examination.

The only exceptions are where physical assessments are undertaken by nurses with special training i.e. SEs 13, 14 and 24

16.4.2.4 The initial assessment includes functional examination, where applicable.

16.4.2.5 The initial assessment includes social and economic assessment, where applicable.

16.4.2.6 The initial assessment includes psychological assessment, where applicable.

16.4.2.7 The initial assessment includes cultural assessment, where applicable.

16.4.2.8 The initial assessment results in an initial diagnosis.

16.4.2.9 The initial assessment results in the identification of the patient's medical, nursing or other health needs.

Linked criterion:
7.2.5.2

16.4.3 Health professionals responsible for patient care collaborate to analyse and integrate assessment information.

Standard Intent

A patient benefits most when the personnel responsible for the patient work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established and care decisions are made.

16.4.3 Criteria

16.4.3.1 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

There should be evidence that all clinical professionals dealing with the patient have contributed to the patient's record.

Compliance with the requirements of this and the following criteria will be verified during the ***patient record audit.*** *If notes by a relevant clinical professional are not found, the criterion will be scored PC.*

Linked criteria:
16.4.1.1, 16.4.2.1

16.4.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

16.4.3.3 Patient needs are prioritised on the basis of assessment results.

16.4.3.4 The patient and/or his or her family participate in the decisions regarding the priority needs to be met.

*Compliance will be verified during **patient/parent/guardian interviews and/or** the **patient record audits**.*

16.5 Patient Care

16.5.1 The care provided to each patient is planned and written in the patient's record.

Standard Intent

A single, integrated plan is preferable to a separate care plan recorded by each health professional.

Collaborative care and treatment team meetings or similar patient discussions are recorded. Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.

The organisation decides:

- which orders must be written rather than verbal
- who is permitted to write orders
- where orders are to be located in the patient record.

The method used must respect the confidentiality of patient care information.

16.5.1 Criteria

16.5.1.1 The planned care is provided and noted in the patient's record.

Root criterion.

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

Linked criterion:
16.1.2.3

16.5.1.2 All procedures and diagnostic tests ordered and performed are written into the patient's record.

The term "written" here implies documented evidence. Such evidence may include nurses' and doctors' notes as well as printed reports, which are filed in the patient record.

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

16.5.1.3 The results of procedures and diagnostic tests performed are available in the patient's record.

This criterion will be scored PC if the results are not initialled by the doctor, the treatment plan does not indicate action taken, or the nursing notes do not indicate that the doctor was informed.

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

16.5.1.4 Re-assessments are documented in the patient's record.

16.5.1.5 The patient's plan of care is modified when the patient's needs change.

16.5.2 Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

Standard Intent

Some patients are considered "high-risk" because of their age, condition or the critical nature of their needs. Children are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Policies and procedures are important. They help the personnel understand these patients and services and respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training staff in their implementation.

The special facilities and safety measures required by children need to be specified. It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required for the care team to work effectively
- special consent considerations
- monitoring requirements
- special qualifications or skills of the personnel involved in the care process
- the resuscitation equipment available and how to use it, including appropriate equipment for children.

Clinical guidelines should be incorporated in the process because there are several criteria requiring guidelines to be used. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high risk patients and procedures, e.g:

a) the care of emergency patients
b) the handling, use and administration of blood and blood products
c) the management of contaminated blood supplies (expired, opened or damaged container)
d) the care of patients on life support or those who are comatose

e) the care of patients with communicable diseases
f) the care of immuno-suppressed patients
g) the care of patients on dialysis
h) the use of restraint and the care of patients in restraint
i) the care of young, dependent children
j) the security of newborn babies.

16.5.2 Criteria

16.5.2.1 Policies and procedures for identified high-risk patients and procedures, which include at least items a) to j) in the intent statement are implemented.

The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training the personnel to implement them correctly.

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

Linked criteria:
1.3.2.1
7.2.5.1
9.2.1.8

16.5.2.2 The personnel are trained and use the policies and procedures to guide care.

*Where policies and procedures refer to patient care the same rule as 16.4.2.1 is applied, i.e. compliance will be measured against the relevant areas in the patients' records during the **record audit process.***

By implication, if the policies are implemented, the personnel can be considered to have been trained and this criterion will be scored accordingly. This "training" could take the form of formal in-service training, introduction at orientation to policies, discussions at departmental meetings, case studies, etc.

16.5.3 Risks, benefits, potential complications and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Standard Intent

This section deals with the process of obtaining informed consent from patient and does NOT refer to providing health education in general, which is dealt with in Standard 16.8.

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent. For example, consent may be given verbally, by signing a consent form, or through some other mechanism. Patients and families understand who may give consent in addition to the patient.

Designated personnel are trained to inform patients' parents/guardian and to obtain and document patient consent, e.g. a medical practitioner for a surgical procedure or a nurse for HIV testing. These staff members clearly explain any proposed treatments or procedures to the patient's parent or guardian. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications
- consideration of the surgical and non-surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written, informed consent. Leaders document the processes for obtaining informed consent.

The consent process always concludes with the patients' parent or guardian signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient's parent or guardian acknowledges full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

16.5.3 Criteria

16.5.3.1 There is a documented process for obtaining informed consent.

Root criterion

This section refers to all instances where patients' parent or guardian give informed consent and compliance will be verified during the patient ***record audit****. If consent was not required for the patient records audited, this whole standard becomes NA.*

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 16.5.3.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC because the process has not been implemented.

Linked criterion:
5.6.1.1

16.5.3.2 Patients and parent or guardian are informed about their condition and the proposed treatment.

16.5.3.3 Patients and parent or guardian know the identity of the medical practitioner or other professional practitioner responsible for their care.

Linked criterion:
16.1.1.3

16.5.3.4 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion
*Compliance will be verified during the **patient record audit.** If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient's parent or guardian has been provided with the information indicated in the relevant criteria above. This criterion and the relevant criteria above will be scored C.*

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria above will receive the same score.

Linked criterion:
5.6.1.1

16.5.4 Pre- and post-operative assessments are documented.

Standard Intent

The preoperative anaesthetic assessment determines whether the patient is a good candidate for the planned surgery and may significantly influence the pre- and intra-operative management. The clinical assessment and results of investigations must be available to the doctor performing the assessment. In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition.

Appropriate re-assessments are essential to modify and guide effective treatment.

A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report is available within a time frame needed to provide post-surgical care to the patient. Post operative monitoring is appropriate to the patient's condition and the procedure performed.

Results of monitoring influence intra and post operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

16.5.4 Criteria

16.5.4.1 The patients' initial medical assessment is documented before anaesthesia.

16.5.4.2 The patient's pre-operative diagnosis is recorded before anaesthesia.

There is documented evidence in the form of a detailed policy or guideline indicating who may perform this assessment, i.e. the person responsible for administering the anaesthetic.

Compliance with criteria 16.5.4.1 to 5 will be verified during the ***patient record audit.***

16.5.4.3 A post-operative diagnosis is documented.

16.5.4.4 The names of the surgeon and the names of other personnel as required by law are documented.

16.5.4.5 The patient's physiological status is monitored during the immediate post-surgery period.

16.5.5 *The organisation implements processes to support the patient in managing pain.*

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and reassessment
- communicate with and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs
- educate health service providersin pain assessment and management.

16.5.5 Criteria

16.5.5.1 The assessment process makes provision for patients in pain to be identified.

16.5.5.2 Patients in pain receive care according to pain management guidelines.

There should be evidence that all clinical professionals dealing with the patient's pain management have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment. These records will also be evaluated.

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

Linked criterion:
1.3.2.1

16.5.5.3 Patients and families are educated about pain and pain management.

*Compliance will be verified during the **patient record audit and patient/**parent/guardian **interviews.***

16.5.5.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.4

16.5.6 *The organisation develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. To accomplish this, all personnel are made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End of life care provided by the organisation includes:

a) providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) sensitively addressing issues such as autopsy and organ donation
c) involving the patient and family in all aspects of care
d) responding to the psychological, emotional, spiritual and cultural concerns of the patient and family.

16.5.6 Criteria

16.5.6.1 Policies and procedures regarding end-of-life care at least including elements a) to d) in the intent statement are implemented.

*Evidence can be sought in **patient records** and by observation of the care process. Another example would be the manner in which the policy on withholding resuscitation is applied.*

Linked criteria:
1.3.2.1
5.4.2.1

16.5.6.2 The patient and the family/guardian are involved in care decisions.

The decision should be the patient's parent or guardian, where possible, in terms of whom they consider the most important individual to support them at this time.

16.5.6.3 Pain and primary or secondary symptoms are managed.

16.5.6.4 Interventions address patient and family religious and cultural concerns.

16.6 Medication

16.6.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

Medications brought into the organisation by the patient or his or her family are known to the patient's physician and are noted in the patient's record.

16.6.1 Criteria

16.6.1.1 Policies and procedures that guide the safe prescribing, ordering and administration of medications in the patient care unit are implemented.

Root criterion
These policies need to be developed by all the role-players, i.e. medical practitioners, nurses and pharmacists.

National regulations related to medication prescription and administration will apply.

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

Linked criteria:
1.3.2.1
16.1.1.2
21.1.2.1, 21.3.1.1

16.6.1.2 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1

16.6.2.3
21.3.1.1

16.6.1.3 Only those permitted by the organisation and by relevant law and regulation prescribe medication.

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

Linked criterion:
16.1.1.2

16.6.1.4 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the patient's medical practitioner and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over-the-counter and homeopathic medicines.

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

Linked criterion:
21.3.1.1

16.6.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, , medical practitioner nurse and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed ~~and~~ to evaluate the patient for adverse effects.

The organisation follows national requirements for the reporting of adverse effects. Doctors, nurses and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically “insignificant”.

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

16.6.2 Criteria

16.6.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:
16.1.1.2

16.6.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

16.6.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
16.6.1.2
21.3.1.1

16.6.2.4 Health professionals monitor medication effects on patients collaboratively.

***Patient record audits** should reveal whether the effect of medications, where relevant, was monitored, recorded and brought to the attention of the medical practitioner.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional information may be required. For example, plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

16.6.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

*An **adverse drug reaction** (**ADR**) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance. Compliance is verified during the **patient record audit.***

Documentation showing that the reaction was reported to the medical practitioner and the pharmacist will be sought.

Linked criteria:
7.1.1.7
16.13.1.2
21.6.1.1, 21.9.1.2

16.6.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
16.13.1.2
21.6.1.1, 21.9.1.2

16.6.2.7 The medications prescribed for and administered to each patient are recorded.

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

16.6.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

16.5.3 Criteria

16.6.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerators, etc) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant personnel only.

An unlocked refrigerator in an unlocked room will be scored NC.

16.6.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

The laws and regulations or organisational policy will determine the nature of these medications.

Linked criterion:
21.5.1.16

16.6.3.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion
Compliance needs to be measured against the medicine control regulations.
Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

16.6.3.4 Medications are securely and legibly labelled with relevant information as required by organisational policy.

Critical criterion
National regulations will apply, but must include at least the following:

- *name of ward and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredien;*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number and*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

16.6.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

16.6.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

16.6.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only

Linked criterion:
21.5.1.9

16.6.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion
Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

16.6.3.9 Expiry dates are checked (including those of emergency drugs) and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

16.7 Food and Nutrition Therapy

16.7.1 Food and nutrition therapy appropriate for the patient and consistent with his or her clinical care is regularly available.

Standard Intent

A qualified caregiver orders appropriate food or other nutrients. The patient participates in planning and selecting foods and the patient's family may, when appropriate, participate in providing food. They are educated as to which foods are contraindicated, including information about any medications associated with food interactions. When possible, patients are offered a variety of food choices consistent with their nutritional status.

The nutritional status of the patients is monitored.

16.7.1 Criteria

16.7.1.1 Food, appropriate to the patient, is regularly available.

Compliance is verified during interviews with personnel and patients, especially regarding times of meals and the availability of special diets.

Menus and meal times will be checked.
Linked criterion:
26.4.1.3

16.7.1.2 An order for food, based on the patients' nutritional status and needs, is recorded in the patient's file.

*Compliance will be verified during the **patient record audit**, especially as it relates to the patient's assessment, the care plan and the identification of special dietary requirements. Prescribed diets are ordered and delivered to the patient.*

16.7.1.3 When families provide food, they are educated about the patient's diet limitations.

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

Linked criteria:
16.8.1.3

16.7.1.4 Patients assessed as being at nutrition risk receive nutrition therapy.

Patients could include malnourished children, patients unable to take normal meals for whatever reason, e.g. inability to swallow, specific disease processes. This could include the provision of nutritional supplements or the provision of full parenteral nutrition.

This criterion and those that follow apply only to nutrition therapy and do not include special diets.

*Compliance of all these criteria will be verified during the **patient record audit.***

16.7.1.5 A collaborative process is used to plan, deliver and monitor nutrition therapy.

*This should include the involvement of a dietician if available. Compliance will be verified during the **patient record audit.***

Linked criteria:
1.3.2.1
21.3.1.1

16.7.1.6 Nutrition therapy provided, either oral or intravenous, is written in the patient's record.

16.7.1.7 Response to nutrition therapy is monitored and recorded.

This may take the form of weight/mass checks, laboratory tests for protein and/or lipid levels etc.

16.8 Patient and Family Education

16.8.1 *Education supports patient and family participation in care decisions and processes*

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care and continue care at home. Variables like educational literacy, beliefs and limitations are taken into account.

Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administration, they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.

Community organisations that support health promotion and disease prevention education are identified and, when possible, ongoing relationships are established.

Evidence of compliance will be obtained during the ***patient record audit*** *and/or* ***patient interviews****.*

16.8.1 Criteria

16.8.1.1 Patients and families indicate that they have been informed about the diagnosis.

16.8.1.2 Patients and families indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
5.3.1.2

16.8.1.3 Patients and families are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use etc.

Linked criterion:
16.7.1.3

16.8.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

16.9 Continuity of Care

16.9.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providersmay be involved in providing care. Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

16.9.1 Criteria

16.9.1.1 Policies and procedures that guide the movement of patients within the organisation are implemented.

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

16.9.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

*Compliance for this criterion and the following will be verified during the **patient record audit.***

16.9.1.3 Continuity and Coordination are evident throughout all phases of patient care.

*Compliance for this criterion and the following will be verified during the **patient record audit.***

16.9.1.4 The record of the patient accompanies the patient when transferred within the organisation.

16.9.2 There is a process known to staff to appropriately refer patients for specialised consultation/investigations at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialized treatment that the referring organisation may be unable to provide. The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

16.9.2 Criteria

16.9.2.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
1.2.5.4

16.9.2.2 A copy of the referral note is available in the patient record.

16.9.2.3 Follow-up care based on the findings of investigations/consultations performed outside the organisation are noted in the patient record.

16.9.3 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation and treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be a brief process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

16.9.3 Criteria

16.9.3.1 There is a documented process for transferring patients to other organisations.

Linked criteria:
1.2.5.4
16.9.3.6

16.9.3.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs and establishes arrangements to ensure continuity.

16.9.3.3 The process for transferring the patient considers transportation needs.

16.9.3.4 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

16.9.3.5 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

*Compliance for this criterion and the following will be verified during the **patient record audit.***

16.9.3.6 A copy of the transfer summary is available in the patient record.

Critical criterion

*Compliance for this criterion and the following will be verified during the **patient record audit.***

Linked criterion:
16.9.3.1

16.9.3.7 The health organisation or other internal unit agreeing to receive the patient, is noted in the patient's record.

16.9.4 There is an organised process to appropriately discharge patients.

Standard Intent

The organisation begins to plan for the patients' continuing needs as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when

appropriate, information on coping with disease or disability.
The summary contains at least:

a) the reason for admission
b) the diagnosis of main and significant illnesses
c) the results of investigations that will influence further management
d) all procedures performed
e) the patient's condition at discharge
f) discharge medications and
g) follow-up arrangements.

16.9.4 Criteria

16.9.4.1 There is a documented process to appropriately discharge patients.

Root criterion
Linked criteria:
1.2.5.4, 1.3.2.1

16.9.4.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

Compliance for this criterion and the following will be verified through **patient record audits**

16.9.4.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow-up instructions may be provided to the patient by the doctor or by the nurse, following instructions from the doctor.

The instructions should include medications, wound care, possible complications, return for follow-up care, when and where to obtain urgent care, etc.

16.9.4.4 A discharge summary, which includes at least items a) to g) in the intent statement, is written, by the medical practitioner when each patient is discharged.

This criterion and the next apply to the discharge summary completed by the medical practitioner and not to the nurses' discharge note. Where a discharge summary has only been partially completed i.e. does not include all items a) to g) it will be scored PC. A nurse's discharge note is not acceptable and is scored NC.

16.9.4.5 Each record contains a copy of the discharge summary.

16.10 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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/co-ordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) patient assessment
b) surgical procedures carried out
c) the use of antibiotics and other medications and medication errors
d) the use of anaesthesia
e) the use of blood and blood products
f) patient and family expectations and satisfaction.

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.

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

Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

16.10.1 Criteria

16.10.1.1 There are formalised quality improvement processes for the paediatric care service is developed and agreed upon by the personnel of the service.

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit*

- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

16.10.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits. These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies, e.g. APACHE III. An indicator, in this context, is a measure used to determine improvements in clinical care over time.

Examples:
1. the number of bed sores/post-operative wound infections
2. nosocomial infection rates (barrier nursing/hand washing).

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

16.10.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.

Where the documentation (patient record) audit is a hospital-wide multidisciplinary process, that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

16.11 Patient Rights

16.11.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

16.11.1 Criteria

16.11.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against legislation, where applicable.

Implementation the policies will be evaluated during the patient record audits and patient interviews as well as by observation. This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

16.11.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

16.11.1.3 The personnel respects the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

16.12 Prevention and Control of Infection

16.12.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

16.12.1 Criteria

16.12.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

The department participates in and has documented evidence of, the identification of risks in the~~ir~~ department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

16.12.1.2 Infection control processes includes prevention of the spread of respiratory tract infections.

16.12.1.3 Infection control processes includes prevention of the spread of urinary tract infections.

16.12.1.4 Infection control processes includes prevention of the spread of

infection through intravascular invasive devices.

16.12.1.5 Infection control processes includes prevention of the spread of infection through surgical wounds.

16.13 Risk Management

16.13.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

16.13.1 Criteria

16.13.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of the organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial, legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

16.13.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated. Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
16.6.2.5 and 6

16.13.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

16.13.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

16.13.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 17 THEATRE AND ANAESTHETIC SERVICES

OVERVIEW OF THE OPERATING THEATRE AND ANAESTHETIC SERVICES

Services in the operating theatre and anaesthetic services carry high risk. It is essential that there is collaboration between the personnel in the theatre, infection control, health and safety personnel and those responsible for the supply and maintenance of equipment.

Anaesthesia, sedation and surgical interventions are common and complex processes in a health organisation. They require complete and comprehensive patient assessment, integrated care planning, continued patient monitoring and criteria-determined transfer for continuing care, rehabilitation and eventual transfer and discharge.

Anaesthesia and sedation are commonly viewed as a continuum from minimal sedation to full anaesthesia. As patient response may move along that continuum, anaesthesia and sedation use are organised in an integrated manner. This chapter includes standards on anaesthesia and sedation, during which the patient's protective reflexes needed for ventilator functions are at risk.

The anaesthesia and surgery standards are applicable wherever anaesthesia and/or moderate or deep sedation are used and surgical and other invasive procedures requiring consent are performed. This includes hospital operating theatres, day surgery or day hospital units, dental and other outpatient clinics, emergency services, intensive care areas and any other setting where anaesthesia and surgery are required.

The organisation ensures that an adequate number of suitably qualified and experienced personnel are available at all times to provide for a safe operating theatre and anaesthetic service.

Standards

17.1 Coordination of Patient Care

17.1.1 *During all phases of care, there are qualified individuals responsible for the patient's care.*

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

17.1.1 Criteria

17.1.1.1 The individuals responsible for the patient's care are designated

The focus is on the "core" care-givers, i.e. doctors and nurses.Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists. It is important to assess the availability of theatre teams, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

17.1.1.2 The individuals responsible for the patient's care are qualified

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels, bed occupancy levels, etc.

The level of qualifications required would be dependent on the category of the relevant hospital, for example, a qualified general professional nurse with supervisory or management experience could be suitable as a ward manager) in a small district level hospital, while a tertiary level hospital would need a professional nurse with advanced nursing as well as management qualifications.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.2.1.4, 2.5.1.1

17.1.1.3 The individuals responsible for the patient's care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times. Staff should always introduce themselves to patients/clients. ***Patient interviews*** *will reveal whether staff members introduce~~d~~ themselves to patients.*

Linked criterion:
2.5.1.7

17.1.2 *The operating theatre and anaesthetic services are managed and staffed to provide a safe and effective service.*

Standard Intent

Theatre management personnel work with organisation leaders to ensure adequate and suitable management processes and staffing of the theatre, anaesthetic service and recovery room.

The qualifications of those persons who administer anaesthesia in the hospital are documented in accordance with current professional society standards. There may not be a formally constituted committee, but the function must be performed at some level, for example, in the private sector there are clinical forums where medical practitioners meet with management. These forums include representatives of the theatre nursing staff.

Privileges assigned to individuals may not be documented, but the organisation places restrictions on who may administer anaesthetics. In the private sector, privileging is implied by the fact that anaesthetists are allowed to provide services in an organisation only once their credentials have been checked.

The patient has the right not to be subjected to prolonged anaesthesia for the surgeon's convenience.

17.1.2 Criteria

17.1.2.1 There is a theatre users' committee or equivalent, which meets regularly and consists of representatives of, for example, the surgical staff, the anaesthetic staff, the nursing staff and organisational management.

There may not be a formally constituted committee, but the function must be performed at some level. If there is no committee, there should at least be an agenda item to address problems related to operating theatre services at senior multidisciplinary management meetings.

Linked criterion:
1.2.8.1

17.1.2.2 A senior professional who is suitably qualified and experienced is in charge of the theatre and the recovery area.

A copy of the guidelines of the professional body (e.g. Botswana Society of Anaesthesiologists, Health Professions Council, Nursing and Midwifery Council of Botswana) or a copy of another reputable guideline should be available. These guidelines provide the basis for the organisation's theatre staffing structure.

The individual's qualifications and experience will be compared with the post description to ascertain that person's suitability for the position, e.g.e, the requirements for a referral hospital's operating theatre will differ from those for a primary hospital.

Linked criteria:

1.3.1.1
2.2.1.1

17.1.2.3 Operating theatre rosters ensure that registered nurses with suitable qualifications and experience are present during all shifts for theatre duties, anaesthetic assistance, and for recovery room duties.

Linked criteria:
1.3.1.4
2.1.1.4; 2.2.1.1

17.1.2.4 Anaesthesia is administered only by a qualified anaesthesiologist or qualified nurse anaesthetist.

Critical criterion

Besides specialist anaesthetists, medical practitioners who have undergone training are permitted to administer anaesthesia. Privileges assigned to Individuals may not be documented, but the organisation places restrictions on who may administer anaesthetics, e.g, doctors who are undertaking their post graduate community service period should not be allowed to administer anaesthetics without supervision unless they have been privileged to do so.

The national regulations will apply where anaesthetics are administered by professionals other than medical practitioners (e.g. nurse anaesthetists).

If the organisation cannot provide documented evidence of the above, this criterion will be scored PC.

Linked criterion:
2.5.1.1

17.1.2.5 Trainee anaesthetists are under the supervision of trained anaesthesiologists.

17.1.2.6 The person administering anaesthesia is directly responsible for only one anaesthetic at a time.

17.1.2.7 Anaesthesia is commenced and terminated only in the presence of a member of the staff whose sole duty it is to assist the person administering anaesthesia until such time as the latter indicates that assistance is no longer required.

A copy of the guidelines of the professional body (e.g. Botswana Society of Anaesthesiologists) or a copy of another reputable guideline should be available. These guidelines provide the basis for the organisation's theatre staffing structure.

Check duty rosters and staff allocation/work lists for each operating theatre, i.e. is a scrub nurse, a floor nurse and an anaesthetic nurse allocated for each procedure? Establish what happens after hours, i.e. ask how many people of what categories are on call to handle emergencies.

17.1.2.8 The surgeon performing the procedure(s) is available before the anaesthetist commences administering the anaesthetic.

The patient has the right not to be subjected to prolonged anaesthesia for the surgeon's convenience.

This is of particular importance in the private sector, where surgeons have tight schedules and may instruct anaesthetists to commence anaesthesia before they arrive in the operating theatre to save time.

Anaesthesia may also be prolonged in large academic institutions in the public sector, where the specialist surgeon moves between theatres to undertake only the more complicated procedures and leaves the rest of the procedure to other surgeons and students.

Compliance can be assessed observing procedures, checking time recordings in the theatre and patient records and interviewing staff members.

17.1.2.9 There is at least one suitably trained and experienced anaesthetic nurse per operating theatre.

The term here applies to the nurse assigned to assist the anaesthetist during the induction process and to be available to attend to his/her needs for the duration of the anaesthetic. It does not apply to a nurse who administers anaesthetics.

Linked criterion:
17.4.3.1

17.1.2.10 Nursing personnel who are trained in recovery room care are available until the patient has fully recovered.

While various categories of staff may be trained and experienced in recovery room care, a professional nurse with recovery room, anaesthetics or critical care training and experience must always be present.

17.2 Facilities, Equipment, Supplies and Medication

17.2.1 Facilities for safe surgical and anaesthetic care are provided and maintained.

Standard Intent

The design of the operating theatre provides space for the reception, anaesthesia, surgery, recovery and observation of patients.

There are areas for the disposal and collection of used equipment and health waste, including contaminated waste and sharps. Safe and adequate storage space for pharmaceutical and surgical supplies is available, including separate lockable cupboards for schedule 1 (Habit Forming Drugs) substances and other scheduled medicines and for inflammables, according to country-specific regulations.

Theatre personnel are provided with office facilities or a day station, a restroom, washrooms, toilets, changing facilities and a separate space for their personal clothing and theatre clothing.

There are facilities for scrubbing-up procedures in each theatre, with hot and cold running water and elbow-operated taps. There is an anaesthetist's chair, an operating table with Trendelenburg position control, at least one lateral padded straight arm support and an infusion pole. Equipment for patients awaiting surgery includes blood pressure monitoring equipment, vacuum points with ancillary fittings and oxygen points with flowmeters and all ancillary fittings. Space and facilities are available for setting up surgical trays and for autoclaving instruments.

17.2.1. Criteria

17.2.1.1 The design of the operating theatre complex provides space for the reception, anaesthesia, surgery, recovery and observation of patients.

Root criterion
Linked criterion:
1.2.2.3

17.2.1.2 There is direct access to the operating theatres from the receiving, scrubbing-up and recovery areas.

17.2.1.3 The accommodation for patients awaiting surgery is suitably equipped.

This area is often not equipped to handle seriously ill patients who require specialised equipment and care.

The assessor must establish what arrangements are in place to accommodate this situation. Either the patient must be taken directly into the operating theatre from the ward or be held temporarily in the recovery room where the necessary equipment and personnel are available.

17.2.1.4 There is safe and adequate storage space for pharmaceutical and surgical supplies.

Control of access to pharmaceutical supplies must be evident. Storage space is often at a premium.

Equipment storage may overflow into corridors. Make sure that health and safety requirements are not compromised, especially with regard to blocking escape routes.

Linked criteria:
1.2.2.3
21.5.1.4 - 11

17.2.1.5 Access to the theatre suites is controlled.

17.2.1.6 There is access to sterilisation and disinfection facilities.

The operating theatre and sterilising department may run as adjacent units or may be entirely separate.

The theatre suite must have access to some form of sterilisation equipment for emergencies, e.g. flash autoclaves.

17.2.1.7 There is a system for controlling the environmental temperature and humidity that ensures safe limits for anaesthetised patients (temperature between 22°C and 25°C and relative humidity between 40% and 70%).

Linked criterion:
29.2.1.4

17.2.1.8 Where resuscitation, intensive care, life support or critical monitoring equipment without built-in battery backup units is used, there is an uninterruptible power supply (UPS), which complies with relevant requirements and is regularly serviced and tested.

Critical criterion

This will be assessed in the theatre suite. It may be necessary to check with the maintenance manager about the servicing and testing of the UPS.

Linked criterion:
29.3.1.4

17.2.1.9 There is either an UPS or a battery backup system for the theatre lamp, which is regularly tested, with such tests being fully documented.

Critical criterion

As above Linked criterion:
29.3.1.4

17.2.1.10 The theatre has a lockable refrigerator for medications, the temperature of which is measured and recorded daily.

Critical criterion

The record of daily checking will be examined.

Linked criterion:
21.5.1.8

17.2.2 Anaesthetic equipment, supplies and medications used comply with the recommendations of anaesthetic professional organisations or alternate authoritative sources.

Standard Intent

Anaesthetic risks are significantly reduced when appropriate and well-functioning equipment is used to administer anaesthesia and monitor the patient. Adequate supplies and medications are also available for planned use and emergency situations. Each organisation understands the required or recommended equipment, supplies and medications needed to provide anaesthetic services to its patient population. Recommendations on equipment, supplies and medications can come from a government agency, national or international anaesthetic professional organisations or other authoritative sources. There is an equipment maintenance programme.

17.2.2 Criteria

17.2.2.1 The recommendations of anaesthetic professional organisations or alternate authoritative sources guide the provision and use of anaesthetic mixture components.

An assessment will be made whether a copy of the guidelines of the country's professional body or a copy of another reputable guideline is available and is used to guide the choice of anaesthetic apparatus.

This will be assessed in the theatre suite and applies to all criteria in this standard.

17.2.2.2 The recommendations of anaesthetic professional organisations or alternate authoritative sources guide the provision and use of breathing circuits.

17.2.2.3 The recommendations of anaesthetic professional organisations or alternate authoritative sources guide the use of scavenging equipment for removing vapours and anaesthetic gases.

17.2.2.4 The recommendations of anaesthetic professional organisations or alternate authoritative sources guide the provision and use of monitoring equipment.

17.2.2.5 The recommendations of anaesthetic professional organisations or alternate authoritative sources guide the provision and use of ancillary equipment.

17.2.2.6 Recommended medications are used.

Either the guidelines of the country's professional body or the national guideline on essential drugs can be used as the basis for deciding which medications should be available.

17.2.2.7 A medication trolley is available for the exclusive use of the anaesthesiologist in each theatre.

17.2.2.8 A tracheotomy tray is available.

Critical criterion

The tray(s) may be kept in the theatre, emergency unit and/or critical care unit. The location will depend upon the services provided by the facility.

Also upon whether the operating theatre personnel are responsible for the performance of tracheostomies or whether they are performed by emergency unit or critical care unit..

Linked criterion:
1.3.1.5

17.2.2.9 Theatre personnel ensure that all equipment is included in the organisation's equipment replacement and maintenance programme.

Linked criteria:
1.2.2.2
31.2.1.5

17.2.3 Emergency and protective equipment are provided in the operating theatre.

Standard Intent

Theatre staff must prepare for any emergencies through the provision of emergency and protective equipment.

17.2.3 Criteria

Evidence of the implementation of the criteria below will be assessed in the theatre suite.

17.2.3.1 Emergency resuscitation equipment is available and functional.

Resuscitation equipment must be available in the theatre and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

A resuscitation trolley should be available at the point of need within 1 minute. In addition, there is access to a defibrillator or automated external defibrillator *(AED) within 3 minutes of any patient collapsing.*

Linked criterion:
30.2.1.2

17.2.3.2 Emergency resuscitation equipment shows evidence of regular checking.

17.2.3.3 There is a mechanism for summoning assistance in an emergency.

17.2.3.4 There is appropriate shielding and protective clothing in the presence of biohazards (including lasers) or radiographic equipment.

Linked criteria:
7.1.1.1, 7.3.1.2

17.2.3.5 Emergency and resuscitation equipment and supplies have clearly defined instructions for use.

17.2.3.6 Hazard or warning notices are displayed.

17.2.4 Recovery room facilities and equipment are available to provide safe and effective care.

Standard Intent

The number of beds/trolley spaces in the recovery room provides sufficient space for at least one patient from each operating theatre that it services, and is sufficient for peak loads. The provision, use and maintenance of recovery room equipment comply with the guidelines for practice of the professional society.

17.2.4 Criteria

Evidence of the implementation of the criteria below will be assessed in the theatre suite.

17.2.4.1 The recovery area forms part of the operating suite.

Linked criterion:
17.2.1.1

17.2.4.2 There are an adequate number of recovery beds for the patients from the operating theatre.

This relates to the provision of sufficient beds/trolleys and the related equipment for each.

Another aspect to be considered is patient privacy at a time when they are particularly vulnerable.

Linked criterion:
5.2.1.1

17.2.4.3 There is adequate lighting.

17.2.4.4 The provision, use and maintenance of recovery room equipment comply with the guidelines for practice of the relevant professional society.

17.3 Clinical Practice Guidelines

17.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits.

This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

17.3.1 Criteria

17.3.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

This section refers to professional guidelines to be used by doctors and nurses for patient care in theatre, whether it is pre-op, intra-op, or post-op. Generally in private organisations the doctors (because they are independent, private practitioners) do not function according to standardised guidelines – each practitioner has his/her own approach.

Each institution should adopt one guideline for use.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

In the absence of guidelines, this criterion will be scored NC.

Linked criterion:
1.3.2.1

17.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criterion:
8.2.1.4

17.3.1.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

17.4 Policies and Procedures

17.4.1 Policies and procedures relating to the activities in the operating theatre are developed and implemented.

Standard Intent

Policies and procedures are necessary to guide the administration of the operating theatre and anaesthetic services to ensure the smooth operation of those services and to ensure that the personnel act swiftly and in a co-ordinated manner in an emergency. Those policies and procedures are made available to all theatre, recovery room and anaesthetic personnel and are known and implemented. Biohazards, which need to be monitored and notified, include radiation, laser and electrical hazards. Policies and procedures are available to ensure that informed consent is documented and the patient is correctly identified; they also make sure that the nature of surgery and the site are correctly documented. Processes during the surgery, such as the use of instruments and counting procedures, are documented to ensure Coordination and safety.

17.4.1 Criteria

17.4.1.1 Written policies and procedures that guide the activities of the theatre and anaesthetic services are implemented.

Root criterion

The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training the personnel to implement them correctly.

The score of this criterion is determined by the scores of the criteria that follow.

Linked criterion:
1.2.6.1

17.4.1.2 Policies and procedures that relate to the duties of the theatre and recovery room nurses are implemented.

17.4.1.3 Policies and procedures that relate to the preparation of patients for surgery are implemented.

Critical criterion
Linked criterion:
17.4.1.1

17.4.1.4 Policies and procedures that relate to theatre cleaning are implemented.

17.4.1.5 Policies and procedures that relate to the notification of biohazards are implemented.

The glossary defines biohazards as 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 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, rickettsiae) and biologically active agents (i.e. toxins, allergens, venoms) that may cause disease in other living organisms or cause significant damage to the environment or community. Biological materials not generally considered to be biohazardous may be designated as biohazardous materials by regulations and guidelines, e.g., the Centre for Disease Control classifies tuberculosis as a level 3 biohazard.

Assessment of compliance will depend upon the type of institution and the types of procedures undertaken. Generally, the assessor should check whether the policy covers all potential hazards, particularly as they relate to the handling of specimens, the disposal of medical waste and the preventive measures to be taken by personnel in respect of hand washing and protective clothing.

How are potentially hazardous substances marked? Is the international biological hazard symbol displayed?

Linked criterion:
7.1.1.1

17.4.1.6 Policies and procedures that relate to medications identified for special control by law or organisational policy are implemented.

Relevant laws and regulations will determine the nature of these medications.

Linked criterion:
21.5.1.11

17.4.1.7 Policies and procedures that relate to patient positioning are implemented.

17.4.2 Policies and procedures are developed relating to the preparation of patients for surgery.

Standard Intent

Policies and procedures are available to ensure that informed consent is documented and the patient is correctly identified; they also make sure that the nature of surgery and the site are correctly documented. Processes during the surgery, such as the use of instruments and counting procedures, are documented to ensure Coordination and safety.

The availability of relevant policies and procedures, as well as their implementation, will be assessed.

17.4.2 Criteria

17.4.2.1 Policies and procedures relating to the scheduling of patients for listed and emergency surgical procedures are implemented.

17.4.2.2 Policies and procedures relating to the patient identification are implemented.

Linked criterion:
7.2.1.1

17.4.2.3 Policies and procedures relating to the verification of the nature and site of the operation are implemented.

Critical criterion
Linked criterion:
7.2.4.1
17.9.1.1

17.4.2.4 Policies and procedures relating to the verification of the last oral intake are implemented.

17.4.2.5 Policies and procedures relating to the checking of consent documents are implemented.

Linked criteria:
5.6.1.1 to 5.6.1.3

17.4.2.6 Policies and procedures relating to specifying the instruments required for specific operations are implemented.

17.4.2.7 Policies and procedures relating to aseptic techniques are implemented.

17.4.2.8 Policies and procedures relating to intra-operative recording required are implemented.

Linked criterion:
17.6.1.4

17.4.2.9 Policies and procedures relating to the recording of tissue(s) and specimen(s) collected are implemented.

Linked criterion:
17.6.1.4

17.4.2.10 Policies and procedures relating to the counting procedures for swabs, instruments and needles, and procedures to be adopted in the event of incorrect counts are implemented.

17.4.3 *Policies and procedures are developed relating to the anaesthetic service.*

Standard Intent

Guidelines of professional societies and associations are available and followed whenever anaesthesia is administered. Implementing these guidelines is particularly important with regard to the qualifications, training and experience needed by personnel in the service. This includes the nurses who assist the anaesthetist and who monitor the recovery of patients. Implementing these guidelines is also particularly important with regard to the provision, maintenance and use of medical equipment and drugs.

Controlling bodies also develop guidelines and regulations relating to professional practice.

Where national guidelines exist, these will be taken into account.

The availability of relevant policies and procedures, as well as their implementation, will be assessed.

17.4.3 Criteria

17.4.3.1 Policies and procedures relating to the required qualifications of persons who administer anaesthetics and of persons who assist the anaesthetist are implemented.

Linked criteria:
17.1.2.4; 17.1.2.9

17.4.3.2 Policies and procedures relating to the pre-operative assessment and pre-medication are implemented.

17.4.3.3 Policies and procedures relating to the administration of anaesthesia are implemented.

17.4.3.4 Policies and procedures relating to assessing the fitness of patients to leave the recovery area are implemented.

This must be assessed together with the criteria related to standard 17.5.3 which states "there is a system to monitor and document each patient's post-anaesthetic status and to discharge the patient from the recovery area according to accepted guidelines."

*The policy must state clearly **who** assesses the fitness of the patient to leave the recovery area and what **criteria** are applied.*

17.4.3.5 Policies and procedures comply with current guidelines of relevant professional bodies.

Is a copy of the guidelines of the professional body available or is there a copy of another reputable guideline, which is used as the basis for the organisation's policies and procedures?

17.4.4 *Policies and procedures guide the care of patients undergoing moderate and deep sedation.*

Standard Intent

Sedation in particular moderate and deep sedation poses risks to patients and thus needs to be provided using clear definitions, policies and procedures. The degrees of sedation occur on a continuum, and a patient may progress from one degree to another, based on the medications administered, route and dosages. Important considerations include the patient's ability to maintain protective reflexes, an independent, continuous patent airway; and to respond to physical stimulation or verbal commands.

Sedation policies and procedures indicate:

a) how planning will occur, and will include the identification of differences between adult and paediatric populations, or other special considerations
b) documentation required for the care team to work and communicate effectively
c) special content considerations, if appropriate
d) patient monitoring requirements
e) special qualifications or skills of staff involved in sedation processes
f) the availability and use of specialised equipment.

17.4.4 Criteria

17.4.4.1 Policies and procedures that address at least, elements a) to f) of the intent statement regarding the care of patients undergoing moderate and deep sedation are implemented.

This refers to the policies, procedures and arrangements that need to be in place when performing procedures under conscious sedation. This type of sedation may be performed in theatre, or in a procedure room e.g. in emergency room (ER), therefore also refer to standard 22.8.2.

If all the policies listed in the intent statement are not available, this criterion will be scored PC.

17.4.4.2 There is a pre-sedation assessment, according to organisation policy, to evaluate risk and appropriateness of the sedation for the patient.

17.4.4.3 A qualified individual monitors the patient during sedation and during the period of recovery from sedation, and documents the monitoring.

Critical criterion
Linked criteria:
17.1.1.2, 17.4.3.1

17.4.4.4 Moderate and deep sedation are administered according to organisation policy.

17.5 Anaesthetic Care

17.5.1 A pre-anaesthetic assessment is conducted and recorded.

Standard Intent

Because anaesthesia carries a high level of risk, its administration is carefully planned. The patient's pre-anaesthetic assessment is the basis for that plan and for the use of post-operative analgesia. The pre-anaesthetic assessment provides information needed to:

- select the type of anaesthesia to be administered and plan anaesthetic care
- identify any drug sensitivities
- safely administer the appropriate anaesthetic and
- interpret the findings of patient monitoring.

An anaesthesiologist or other qualified individual conducts the pre-anaesthetic assessment.

Anaesthetic care is carefully planned and documented in the anaesthetic record. The plan considers information from other patient assessments and identifies the anaesthetic to be used, the method of administration, other medications and fluids, monitoring procedures, and anticipated post-anaesthetic care.

The anaesthetic planning process includes education of the patient and his or her family or decision-maker regarding the risks, potential complications, and options related to the planned anaesthesia and postoperative analgesia. This discussion occurs as part of the process of obtaining consent for anaesthesia. The anaesthesiologist or the qualified individual who will administer the anaesthetic provides this education.

17.5.1 Criteria

*All the criteria related to this standard will be assessed by undertaking **an audit of randomly selected records of patients** who have undergone surgical procedures. Documented evidence of the requirements will be sought and marked accordingly.*

17.5.1.1 Patients have an anaesthetic assessment performed before the administration of anaesthesia.

Root criterion

*The score of this criterion is determined by the scores of the criteria that follow. Compliance will be verified during the **patient record audit.***

17.5.1.2 The medical assessment of surgical patients is documented before the start of the anaesthesia.

17.5.1.3 The patient, family and decision-makers are educated regarding the risks and, potential complications of, and options related to the anaesthesia.

17.5.1.4 The anaesthesiologist or other qualified individual provides that education.

17.5.2 Each patient's physiological status is monitored and recorded during anaesthesia and surgery.

Standard Intent

The anaesthetist monitors and records the physiological status of the patient during anaesthesia, and enters the drugs and intravenous fluids used, and the anaesthetic, in the patient's anaesthetic record.

The anaesthetist has access to the patient care notes, and is familiarised with the findings of the medical examination. It is important that each health professional has access to the records of other care providers, in accordance with organisational policy.

All the criteria related to this standard will be assessed by undertaking an audit of randomly selected records of patients who have undergone surgical procedures.

If copies of the intra-operative records are not available in the patient records, it must be established if they are kept elsewhere, e.g. by the anaesthetists.

Wherever the records are kept, documented evidence will be sought and the criteria marked according to findings.

17.5.2 Criteria

*All the criteria related to this standard will be assessed by undertaking an **audit** of randomly selected **records of patients** who have undergone surgical procedures.*

If copies of the intra-operative records are not available in the patient records, ask whether they are kept elsewhere, e.g. by the anaesthetists.

Wherever the records are kept, documented evidence will be sought and the criteria marked according to the findings.

17.5.2.1 The patient's physiological status is continuously monitored during the anaesthesia and surgery.

17.5.2.2 The results of such monitoring are entered into the patient's record.

Critical criterion
Linked criterion:
17.6.1.4
17.9.1.1

17.5.2.3 The anaesthetic used is entered into the patient's anaesthetic record.

17.5.3 There is a system to monitor and document each patient's post-anaesthetic status, and to discharge the patient from the recovery area according to accepted guidelines.

Standard Intent

Physiological monitoring provides reliable information about the patient's status during the administration of anaesthesia and the recovery period. Monitoring methods depend on the patient's pre-anaesthetic status, anaesthetic choice and the complexity of the surgical or other procedures performed during anaesthesia. In all cases, however, the monitoring process is continuous and the results are entered into the patient's record.

Monitoring during anaesthesia provides the basis for monitoring during the post-anaesthetic recovery period. The ongoing, systematic collection and analysis of data on the patient's status in recovery may support decisions about moving the patient to other settings and less intensive services. Only a suitably qualified and experienced registered nurse or a designated member of the medical staff may carry out monitoring in the recovery area. Recording of monitoring data provides the documentation to support discharge decisions.

Patients are discharged from the post-anaesthesia recovery area in the following ways:

a) The patient is discharged by a fully qualified anaesthetist or other individual authorised by the individual(s) responsible for managing the anaesthetic service
b) The patient is discharged by a nurse or similarly qualified individual in accordance with post-anaesthesia criteria developed by the organisation's leaders and the discharge is documented in the patient's record
c) The patient is discharged to a unit which has been designated as appropriate for post-anaesthesia or post-sedation care of selected patients, such as an intensive care unit.

The time of arrival in, and discharge from, the recovery area are recorded. Signatures of those who hand over and those who receive the patient are recorded.

17.5.3 Criteria

17.5.3.1 The anaesthetist is responsible for supervising the recovery period.

This applies whether the anaesthetic is administered by a medical practitioner or a nurse anaesthetist.

Linked criterion:
1.3.2.1

17.5.3.2 Monitoring is appropriate to the patient's condition during the post- anaesthetic recovery period.

There will be situations where patients bypass the recovery room and are transferred straight from the operating theatre to the intensive care unit.

In smaller hospitals, there may not be a dedicated recovery room or recovery room staff and the patient will be returned to consciousness in the theatre and transferred directly to the ward.

17.5.3.3 The qualifications and experience of staff members who may monitor patients are documented.

17.5.3.4 Monitoring findings are entered into the patient's record.

*This will be assessed during the **patient record audit**.*

17.5.3.5 Established criteria are used to make decisions to discharge patients from the recovery room.

*The criteria may be documented in a policy/procedure or printed on the recovery room section of the intra-operative record. A documented record of their application will be sought during the **patient record audit**.*

*The policy must state clearly **who** assesses the fitness of the patient to leave the recovery area and what **criteria** are applied.*

17.5.3.6 The individual responsible for discharging the patient according to items a) and b) in the intent statement signs the discharge in the patient record.

Critical criterion

The designated recovery room nurse may apply the criteria and inform the anaesthetist of the patient's readiness to be discharged from the recovery room. A verbal instruction from the anaesthetist must be treated in the appropriate manner, i.e. such verbal instruction should be verified by a second nurse and the patient record should reflect both signatures - that of the responsible recovery nurse as well as the witnessing nurse. (In other words, the same professionally accepted principles are applied as for a verbal medication order).

In general, the anaesthetist remains responsible for the final decision to release the patient, but national arrangements will be taken into account.
*Compliance will be verified during the **patient record audit.***
Linked criterion:
17.6.1.4

17.5.3.7 Recovery area arrival and discharge times are recorded.

17.5.3.8 Signatures of those handing over and of those receiving the patient are recorded.

17.6 Quality improvement

17.6.1 A formalised proactive quality improvement approach is maintained in the theatre and anaesthetic services.

Standard Intent

This refers to the implementation of organisational quality improvement processes (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/co-ordinating quality management structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include items from the WHO Surgical Safety Checklist (www.safesurg.org) such as:

a) surgical site infection
b) unplanned return to the operating theatre
c) surgical deaths
d) case length
e) length of the operating day
f) the number of times blood was not available, .

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
- 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.

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

Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

17.6.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of

- *at least one clinical audit,*
- *participation in documentation (patient record) audits and*

- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

17.6.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on patient care, this cannot be compliant if there is no evidence of clinical audits.
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*
- *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 results, where appropriate*

The information gained must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

If there are no clinical audits, the highest possible score is PC.

17.6.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.
Where the documentation (patient record) audit is a hospital-wide multidisciplinary process-that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.
Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

17.7 Patient Rights

17.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

17.7.1 Criteria

17.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the ***patient record audits*** *and patient interviews, as well as by observation*
.
This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

17.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

17.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

17.8 Prevention and Control of Infection

17.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes on infection prevention and control (Service Element 9).

17.8.1 Criteria

17.8.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide infection control programme.

Linked criterion:
9.2.1.1

17.8.1.2 Infection control processes include prevention of the spread of respiratory tract infections.

17.8.1.3 Infection control processes include prevention of the spread of urinary tract infections.

17.8.1.4 Infection control processes include prevention of the spread of infection through intravascular invasive devices.

17.8.1.5 Infection control processes include prevention of the spread of infection through surgical wounds.

17.9 Risk Management

17.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

17.9.1 Criteria

17.9.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1
17.4.2.3, 17.5.2.2

17.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated in the theatre suite. Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7; 7.2.6.4

17.9.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated in the theatre suite.

Linked criterion:
7.4.1.4

17.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated in the theatre suite.

Linked criterion:
7.5.1.1

17.9.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in theatre suite. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 18 NUCLEAR MEDICINE SERVICE

OVERVIEW OFTHE NUCLEAR MEDICINE SERVICE

Organisations may provide nuclear medicine services as part of an integrated system of services, or may have an arrangement with an outside source for the referral of patients.

The selection of an outside source is based on an acceptable record and compliance with laws and regulations.

Where the organisation provides its own nuclear medicine services, these comply with applicable international and national standards, laws and regulations.

Radiation safety programmes are complied with, and policies and procedures guide staff in the application of safety measures.

Standards

18.1 Management of the Service

18.1.1 *Where the organisation provides on-site nuclear medicine services, the service is organised and managed* in accordance with applicable laws, regulations and standards.

Standard Intent

Where the organisation provides an on-site service, suitably qualified and experienced managers ensure that the service is managed in accordance with applicable laws, regulations and standards.

18.1.1 Criteria

18.1.1.1 Nuclear medicine services are under the direction of one or more qualified individuals.

18.1.1.2 All professional staff are currently registered with the health professions council.

18.1.1.3 There are qualified nuclear radiographers to provide services in keeping with the scope of their profession.

18.1.1.4 A qualified medical radiation physicist is available to fulfil the legal requirements of the regulations for the safe use of ionising radiation.

Critical criterion
Linked criterion:
1.2.1.4

18.1.1.5 The services of a qualified radio-pharmacist or nuclear medicine radiographer are available for radio-pharmaceutical preparations.

National requirements need to be taken into consideration and the required evidence can be obtained from various sources such as post specifications, or job description. Where applicable, there should be evidence of registration with the relevant professional council.

Linked criteria:
1.3.1.1, 1.2.7.2
2.2.1.1, 2.5.1.1

18.1.1.6 The responsibilities of this person include developing, implementing and maintaining policies and procedures.

Linked criteria:
1.2.6.1
18.3.2.1

18.1.1.7 The responsibilities of this person include administrative control.

The manager is usually responsible for all administrative functions e.g. signing of leave forms, financial control, ordering of supplies, arranging servicing of equipment, etc.

Scoring of this criterion is based on evidence of implementation.

18.1.1.8 The responsibilities of this person include maintaining quality control programmes.

18.1.1.9 The responsibilities of this person include monitoring and reviewing all nuclear medicine services.

Monitoring systems to review the service provided should be implemented. These can include regular staff meetings, patient satisfaction questionnaires, stock control, the monitoring of waiting times and should also include the quality control and radiation safety aspects.

18.2 Referral Services

18.2.1 Where there is an arrangement with an outside service, this service meets applicable and national standards, laws and regulations.

Standard Intent

The organisation has a system for providing nuclear medicine services required by its patient population, clinical services offered, and health provider needs. These services may be provided by agreement with another organisation. The organisation defines the time period for reporting nuclear medicine results. Results are reported within a time frame based on patient needs, services offered, and the clinical staff's needs. Emergency tests, after-hours and weekend testing needs are included. The reports are submitted timeously, in accordance with arrangements.

When the organisation uses outside sources of nuclear medicine services, they receive and review, on a regular basis, the quality control results of the outside source. Qualified individuals review the quality control results.

Patients are informed, when the referring physician owns an outside source of nuclear medicine services.

18.2.1 Criteria

18.2.1.1 Adequate, convenient and regular nuclear medicine services are available to meet needs.

Root criterion that addresses a number of issues.

"Adequate" one should take into consideration the level of service that is required. The service should meet the needs of the population that it serves e.g. if the service is only available 2 or 3 days per week, but the need is there for a daily service, then this would warrant a PC score.

If equipment is broken or supplies are lacking, or staff are inadequate and the full scope of service (as required) cannot be rendered then the criterion should be scored down.

"Convenient" refers to the patient's experience and it should be considered that sometimes patients are referred "unnecessarily" somewhere else because of staff shortage, broken equipment, lack of supplies, etc.

"Regular" refers to the hours of operations and whether an after hour service is available or not this should be measured against the needs of the hospital and other clients that the medical physics service may serve, e.g. surrounding hospitals and clinics.

Linked criteria:
1.2.7.2, 1.3.1.7

18.2.1.2 The selection of an outside source is based on an acceptable record and compliance with relevant laws and regulations.

If the specific service is not available in the facility, and patients are referred to an outside source for specialised investigations, this criterion becomes applicable. In case of the latter there needs to be applicable documentation, either a Service Level Agreement (SLA), Memorandum of Understanding (MOU), contract or memorandum, which include documentation that this facility applies with the applicable laws and regulations.

Linked criterion:
1.2.7.2

18.2.1.3 Patients are informed about any relationships between the referring physician and outside sources of nuclear medicine services.

This does not generally apply to public institutions, where referral systems are dictated by policy. In that case, this criterion will be scored NA.

Wherever a patient is referred for diagnostic imaging services to another facility, the reason for this must be explained to the patient. Evidence of compliance will be sought during the ***patient record audit and patient interviews.***

In private facilities, where the referring medical practitioner has an arrangement to send patients to a particular facility, this must be brought to the attention of the patient, especially if the referral inconveniences the patient in any way.

Linked criterion:
1.2.5.1

18.2.1.4 The nuclear medicine services provided meet applicable local and national standards, laws and regulations.

18.2.1.5 The organisation has established the expected report time for results, within a time frame to meet patient needs.

A policy needs to be available to define the time period within which the reporting will be done.

18.2.1.6 Reports are clearly labelled with the name of the patient, and the date and time of the procedures.

18.2.1.7 Quality control results from outside sources are regularly reviewed.

Linked criterion:
1.3.1.8

18.2.1.8 Qualified individuals review the quality control results.

18.3 Radiation Safety

18.3.1 A radiation safety programme is in place, followed and documented.

Standard Intent

The organisation has an active radiation safety programme, appropriate to the risks and hazards encountered. The programme addresses safety practices and prevention measures for nuclear medicine staff, other staff and patients. The programme is co-ordinated with the organisation's safety management programme.

The radiation safety programme includes:

- written policies and procedures, which support compliance with applicable standards, laws and regulations
- written policies and procedures for the handling and disposal of infectious and hazardous materials
- the availability of safety protective devices appropriate to the practices and hazards encountered
- the orientation of all nuclear medicine staff to safety procedures and practices; and
- in-service education for new procedures and newly acquired or recognised hazardous materials.

18.3.1 Criteria

18.3.1.1 A radiation safety programme is in place and is appropriate to the risks and hazards encountered.

Root criterion for all the following criteria in this standard

Linked criteria:
18.3.1.3, 18.3.4.2, 18.8.1.1

18.3.1.2 The programme is co-ordinated with the organisation's safety management programme.

18.3.1.3 Personal dosimeters worn by staff comply with the ionising radiation regulations.

Critical criterion
Linked criterion:
18.3.1.1

18.3.1.4 Appropriate radiation safety devices are available.

18.3.1.5 Written records of radioactive stocks, calculation and preparation, administration and disposal details are kept.

18.3.1.6 A register is kept of sealed sources.

18.3.1.7 Contamination monitors are provided.

18.3.1.8 Area monitors are available, where necessary.

18.3.2 There are written policies and procedures to guide staff in all aspects of the provision of nuclear medicine services.

Standard Intent

Written policies and procedures are essential to guide staff in the nuclear medicine service in their activities. The existence of written procedures does not preclude modification in the best interests of the patient.

Nuclear medicine policies and procedures are related to the requirements or availability of other services in the hospital environment.

18.3.2 Criteria

18.3.2.1 Written policies and procedures that address compliance with applicable standards, laws and regulations are implemented.

Root criterion

Policies and procedures should include at least the following:
- *The qualifications of staff*
- *Radiation safety, including radiation safety inspections, signage in the department, the handling and disposal of hazardous material, over-exposure, the wearing of dosimeters*
- *X-rays of pregnant women*
- *Requesting X-rays*
- *Reporting on films including the time frames for reporting*
- *The availability of emergency drugs and equipment.*

Linked criteria:
1.2.1.4, 1.2.1.5
18.2.1.6

18.3.2.2 The associated medical physicist is involved in the formulation of polices and radiation safety procedures, applicable to nuclear medicine.

18.3.2.3 Policies and procedures that satisfy statutory requirements under the ionising radiation regulations are implemented.

18.3.2.4 A copy of the local rules, relating to current ionising radiation regulations, is available.

National arrangements will apply, this will include:
- *A copy of the Radiation Protection Act 2006.*
- *Relevant guidelines and policies from the Radiation Protection Inspectorate (RPI),*

Where the national regulations are silent on the rules, guidelines should be sought from international radiation protection organisations such as the International Commission for Radiation Protection (www.icrp.org).

18.3.2.5 Policies and procedures that relate to limiting the irradiation of patients to levels consistent with medical requirements are implemented. The ALARA (as low as reasonably achievable) principle is applied to the calculation, preparation and administration of radioactive doses.

18.3.2.6 A strict policy on the terms under which pregnant women may be subjected to a nuclear medicine examination is available and implemented.

18.3.2.7 There is a procedure to ensure professional handling of a radiation emergency situation.

18.3.2.8 Policies and procedures that relate to avoiding radioactive contamination and controlling spread should it occur are implemented.

18.3.2.9 A written procedure is available for staff to follow in the event of contamination.

18.3.2.10 Policies relating to monitoring the hands, clothing and body of every member of staff leaving a controlled area are implemented.

18.3.2.11 Policies and procedures are implemented for the reporting of adverse reactions to therapy.

18.3.2.12 Policies and procedures are implemented for clinical trials, where applicable.

18.3.2.13 Policies and procedures that address the handling and disposal of infectious and hazardous materials are implemented.

Critical criterion
Linked criterion:
1.2.7.3
18.8.1.1

18.3.2.14 Nuclear medicine staff are oriented to safety procedures and practices.

18.3.2.15 Personnel receive education with regard to new procedures and newly acquired or recognised hazardous materials.

18.3.3 All diagnostic equipment is regularly inspected and maintained, and appropriate records are kept of those activities.

Standard Intent

Nuclear medicine staff works with medical equipment management to ensure that all equipment and facilities function at acceptable levels and in a manner that is safe for the operator(s). A nuclear medicine equipment management programme provides for:

- selecting and acquiring equipment
- identifying and taking an inventory of equipment
- assessing equipment use through inspection, testing and maintenance
- monitoring and acting on equipment hazard notices, recalls, reportable incidents, problems and failures
- documenting the management programme.

Testing and maintenance are related to the use of the equipment and its documented history of service.

18.3.4 Criteria

18.3.4.1 There is a nuclear medicine equipment management programme.

18.3.4.2 The programme includes selecting and acquiring equipment.

18.3.4.3 The programme includes taking an inventory of equipment.

18.3.4.4 The programme includes inspecting and testing the equipment.

18.3.4.5 The programme includes maintaining the equipment.

18.3.4.6 The programme includes monitoring and follow-up of the equipment.

18.3.4.7 Radiation monitors are calibrated regularly.

18.3.4.8 Values are recorded in a log book.

18.3.4.9 The programme is followed.

18.3.4.10 There is adequate documentation of all testing, maintenance and calibration of equipment.

18.3.5 Facilities ensure the safe, efficient and effective functioning of the nuclear medicine service.

Standard Intent

Nuclear medicine personnel work with management to ensure that facilities provide for safety and that they comply with current nuclear medicine laws and regulations.

18.3.5 Criteria

18.3.5.1 Facilities ensure that radiation to staff is kept as low as possible.

18.3.5.2 At every entrance to a room, where radioactive material is handled, a radiation warning sign is displayed.

Linked criterion: *18.3.1.1*

18.3.5.3 Requirements laid down by the Department of Radiation regarding a controlled area are complied with.

18.3.5.4 A copy of the most recent radiation safety inspection report is held by the nuclear physician, responsible for the department, or the medical physics department, or medical physicist.

18.3.5.5 There is a shower available in the event of contamination.

18.3.5.6 Separate toilets for staff and patients are available.

18.3.5.7 Signs warning of the dangers of radiation to pregnant and breast-feeding women are prominently displayed.

18.3.6 Radio-pharmaceuticals intended for administration to patients are prepared in a manner which satisfies both radiation safety and pharmaceutical quality requirements.

Standard Intent

Sound quality control systems are essential to providing excellent nuclear medicine services. Quality control procedures include:

- validation of the procedures used
- daily surveillance of results by a nuclear medicine physician
- rapid corrective action, when a deficiency is identified
- documentation of results and corrective actions.

18.3.6 Criteria

18.3.6.1 Appropriate aseptic precautions are taken.

18.3.6.2 Regular and frequent gamma camera quality control procedures (e.g. flood uniformities, centre-of-rotation) are attended to or supervised by the medical physicist.

18.3.6.3 The radio-pharmacy is designed to ensure that the history of each radio-pharmaceutical dose can be traced.

Critical criterion
Linked criterion:
1.2.1.4
18.3.5.9, 18.8.1.1.

18.3.6.4 Radio-pharmaceuticals are only dispensed on written request.

18.3.6.5 All details of each Tc-99m generator are recorded, including full details of each elution.

18.3.6.6 Facilities are available for the quality control of all kits, reconstituted on the premises.

18.3.6.7 There are separate facilities for the radio labelling of blood products.

18.3.6.8 Blood products are labelled in a workstation with filtered air (at least a vertical laminar flow unit of biohazard type) to protect the product and designed to protect the operator against contamination.

18.3.6.9 All containers with radioactivity are labelled according to specifications, stating that the contents are radioactive and indicating the activity and the date.

Critical criterion:
Linked criterion:
18.3.5.3

18.3.7 The management of organ disease using open radio-nuclides is practised taking into account the safety and well-being of patients and staff, as a consequence of the high radiation levels.

Standard Intent

Where open radio-nuclides are used, all staff and patients in the organisation are protected from exposure to radiation by following established guidelines, which are formulated by experts in the field. Supervision ensures that the guidelines are adhered to.

18.3.7 Criteria

18.3.7.1 Where radioactive material administered to the patient exceeds a level of 370 MBq (10mCi), it is administered by the nuclear physician or radiation oncologist only.

18.3.7.2 Where radioactive material administered to the patient exceeds a level of 370 MBq (10mCi), there is an en-suite ward approved by the medical physicist for the isolation of the patient.

18.3.7.3 In the event that the approved ward is not available, any alternative ward for the isolation of the therapy patients is also approved by the medical physicist.

18.3.7.4 A radiation survey of the ward, used for the isolation of the patient and adjacent areas, is conducted according to the requirements of the physicist immediately after the administration of the radioactive material.

18.3.7.5 The isolated patient is monitored regularly during the isolation period.

18.3.7.6 On discharge of the patient, who has been isolated, the ward, the bedding and the bathroom are monitored, according to the requirements of the physicist.

18.3.7.7 Orally administered radio-iodine is always in capsule form.

18.3.7.8 Radio-iodine by injection (e.g. MIGB) is administered only by the nuclear physician or radiation oncologist.

18.3.7.9 A fume hood is used if liquid radio-iodine is being prepared, and the staff preparing the radio-iodine is adequately protected.

18.3.7.10 Administration of all radio-nuclides for therapy purposes is done in consultation with the physicist and according to statutory radiation safety norms.

18.4 Administration of Tests

18.4.1 Individuals with adequate training, skills, orientation and experience administer tests and interpret the results.

Standard Intent

The organisation identifies which nuclear staff members may assess patients and who may interpret and report on results. Staff has appropriate and adequate training, experience and skills and is oriented to their work. Staff is given work assignments consistent with their training and experience. In addition, there is a sufficient number of staff to perform procedures promptly and provide the necessary staffing during all hours of operation and for emergencies.

18.4.1 Criteria

18.4.1.1 Examinations are performed only upon a formal request from a medical practitioner.

18.4.1.2 Nuclear medicine procedure requests contain all relevant clinical information.

18.4.1.3 If relevant radionuclides are available, all examinations are

performed as soon as possible. Urgent scans are performed and reported on the same day.

18.4.1.4 Those individuals, who perform testing and those who direct or supervise testing, are identified.

This criterion requires the availability of an organisational chart which reflects the persons required to provide an adequate service for the facility. However, where there are a number of vacant posts, this criterion can only be scored PC. The organisational chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criteria:
1.1.1.2, 1.2.7.2
2.2.1.1

18.4.1.5 Tests are interpreted by appropriately trained and experienced staff.

18.4.1.6 Only a nuclear medicine physician, or a registrar under supervision of a nuclear medicine physician, or a radiologist, may report on the results of nuclear medicine procedures.

18.4.1.7 An effective mechanism exists whereby emergency nuclear medicine procedure results are brought to the attention of the doctor, who requested the examination.

18.4.1.8 Nuclear medicine procedure results are handled in a professional and confidential manner.

18.4.1.9 Reports are appropriately filed/ distributed.

18.4.1.10 Mechanisms exist, whereby the results of procedures can be retrieved, when necessary.

18.5 Quality Improvement

18.5.1 A formalised proactive quality improvement approach is maintained in the nuclear medicine service.

Standard Intent

This refers to the implementation of organisational quality improvement processes (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 the managers to ensure that standards are set for the particular department. This requires Coordination with the organisation's central/management/co-ordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.
Quality monitoring could include:

a) request forms without history or clinical diagnosis

b) number of unidentified patients
c) unescorted patients arriving at the department
d) waiting times
e) patient and family expectations and satisfaction.

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 problem
- 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 tables results, as appropriate.

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

Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

18.5.1 Criteria

18.5.1.1 There are formalised quality improvement processes for the nuclear medicine service, which has been developed and agreed upon by the personnel of the service.

Once the nuclear medicine service has analysed its mission, defined its objectives, and identified all its stakeholders, there needs to be a way in which progress towards achieving these objectives can be measured.

The minimum requirement for considering compliance will be the availability of evidence of:

- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

18.5.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

Performance indicators are quantifiable measurements, determined beforehand, that will reflect the quality of the service or department.
Performance indicators could include:

- *turnaround times*
- *correct completion of request forms*

The quality improvement programme should also concentrate on the deficiencies outlined in the routine quality assurance inspections, but especially attempts that are made to minimise the radiation dose to the patient. This latter aspect is receiving much attention at the moment, viz. the issue of so-called diagnostic reference levels (DRL's).

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

Regular measurements should be done to check on the performance indicators as above and these results will allow for on-going monitoring of either poor performance against the standards, or improvements over time. Ongoing monitoring is required in order to demonstrate that improvements are being sustained.

18.5.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.

Where the documentation audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

18.6 Patient Rights

18.6.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

18.6.1 Criteria

18.6.1.1 There are processes, which support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. The implementation thereof will be evaluated during the auditing of patient records, patient interviews and observation in the department.

This applies to all the relevant criteria below.

Linked criterion:

5.1.1.3

18.6.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Special emphasis should be placed that privacy is maintained at all times; especially during dressing/undressing, walking to the treatment room in front of other patients, etc.

Linked criteria:
4.1.1.6
5.2.1.1-3
6.1.2.1

18.6.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

18.7 Prevention and Control of Infection

18.7.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

18.7.1 Criteria

18.7.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide infection control programme.

A number of aspects need attention in this department, i.e. availability of linen and gowns; infection control measures to be implemented during invasive procedures; the use of masks if patients are on oxygen, etc. One should also consider whether these aspects are catered for in the overall infection control programme.

Other aspects to include are the general housekeeping practices (cleaning of the department, hand washing aspects, cleaning of equipment including sonar probes, etc.).

Linked criterion:
9.2.1.1

18.7.1.2 Infection control processes includes prevention of the spread of

infection through invasive devices.

18.8 Risk Management

18.8.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

The organisation has an active radiation safety programme that includes all components of the organisation's nuclear medicine services, including nuclear medicine, radiation oncology and the cardiac catheterisation laboratory. The radiation safety programme reflects the risks and hazards encountered. The programme addresses safety practices and prevention measures for nuclear medicine staff, other staff and patients. The programme is co-ordinated with the organisation's safety management programme.

18.8.1 Criteria

18.8.1.1 The department conducts on-going monitoring of risks through documented assessments as part of the organisational programme.

Root criterion

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial, and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criteria:
7.1.1.1
18.3.1.3, 18.3.2.13, 18.3.5.3

18.8.1.2 A system for the monitoring of negative incidents/near misses/ adverse (sentinel) events is available, which includes the documentation of interventions and responses to recorded incidents.

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

18.8.1.3 Security measures are in place and implemented for the safeguarding and protection of patients, staff and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criteria:
7.4.1.4

18.8.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

18.8.1.5 Organisation policy on handling, storage and disposal of health waste generated by nuclear medicine procedures is implemented.

The implementation of the facility's master policy will be evaluated during the walk-about through the department. The process must include handling at source, collection, storage and disposal of all waste, including radiological waste. Specific focus will be placed on the recovery of silver in the conventional units, and documented evidence that the radiology equipment (tubes, etc.) has been condemned with approval from Radiation Protection Inspectorate or equivalent.

The practice whereby used reagents are poured down the sewerage system needs high authority intervention in some case.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 19 LABORATORY SERVICE

OVERVIEW OF THE LABORATORY SERVICE

Laboratory investigations and rapid reporting systems are essential for patient assessment and the implementation of treatment plans.

The hospital may have its own laboratory service, or it may have an arrangement with an outside licensed/approved laboratory service, for accepting laboratory specimens for analysis. In either case, the service must meet applicable laws and regulations.

The selection of an outside source is based on an acceptable record and compliance with laws and regulations.

Laboratory services must be available at all times needed by the organisation, including emergency and after-hour services.

19.1 Management of the Service

19.1.1 Laboratory services are available to meet the needs of patients, in compliance with local and national laws, regulations and standards

Standard Intent

The organisation has a system for providing the laboratory services, including clinical pathology services, required by its patient population, clinical services offered, and health providers' needs.

The laboratory services are organised and provided in a manner that meet applicable local and national standards, laws and regulations.

Laboratory services, including those required for emergencies and after-hours, may be provided within the organisation, by agreement with another organisation, or both if outside sources are convenient for the patient to access. The organisation selects outside sources based on the recommendations of the director or other individual responsible for laboratory services. Outside sources of laboratory services have an acceptable record of accurate, timely services. Patients are informed when an outside source of laboratory services is owned by the referring physician.

19.1.1 Criteria

19.1.1.1 Adequate, convenient and regular laboratory services are available to meet the organisation's needs.

Root criterion that addresses a number of issues.

With "adequate" one should take into consideration the level of service provided by the hospital, the available specialties, whether this is a referral laboratory or not, physical facilities, work space, availability and functional status of equipment, availability of required number of qualified staff in terms of workload, etc.

Also to be taken into account is the alternative arrangements (referral of tests to other laboratories) in case the laboratory cannot provide the service.

"Convenient" refers to the location and accessibility of the laboratory, as well as the hours of operation (also included in the statement on "regular services").

"Regular" refers to the hours of operations and whether an after-hour service is available or not, this should be measured against the needs of the hospital and other clients that the laboratory may serve, e.g. surrounding hospitals and clinics.

This would include the after-hour service. If there is no service available when required, this criterion will be scored PC.

Linked criteria:
1.2.7.2, 1.3.1.7
19.1.3.6
23.6.1.1

19.1.1.2 The laboratory services are organised and provided in a manner that meets applicable national standards, laws and regulations.

National requirements need to be considered and these may include: licensing, staffing norms and qualifications, scope of practice, etc. This criterion also requires the existence of policies and procedures to guide all managerial functions and operational activities in the laboratory. Such policies may be originated at higher levels (national, regional, head office) or in the local laboratory itself.

Linked criterion:
1.2.6.1

19.1.1.3 Emergency laboratory services are available, including after-hours services.

Policy needs to define the alternative arrangements to be in place should the on-site laboratory not provide any after hour service.

If there is no service available when required, this criterion will be scored NC.

Linked criteria:
2.2.1.5
22.7.2.1,
24.7.2.1

19.1.1.4 A list of referral laboratories is available for tests not performed on site.

19.1.2 A qualified individual is responsible for managing the laboratory service.

Standard Intent

The laboratory service is under the direction of a qualified person, who has documented evidence of training, expertise and experience and who is registered by the Health Professions Council in accordance with applicable laws and regulations. This qualified person assumes professional responsibility for the laboratory facility and for the services provided. When this individual provides clinical consultations or medical opinions, he or she is a physician, preferably a pathologist. Speciality and subspecialty laboratory services are under the direction of appropriately qualified individuals. Responsibilities of the laboratory director/manager include the:

- ordering of tests
- collecting and identifying of specimens
- transporting, storing and preserving of specimens
- receiving, logging in and tracking of specimens.

These procedures are also observed for specimens sent to outside sources for testing.

19.1.2 Criteria

19.1.2.1 The laboratory is under the direction of a qualified individual.

National requirements need to be taken into consideration and the required evidence can be obtained from various sources such as post specifications, or job description.

Where applicable, there should be evidence of registration with the relevant professional body/council.

Linked criteria:
1.3.1.1
2.2.1.1, 2.5.1.1

19.1.2.2 The responsibilities of this person include maintaining quality control programmes.

This serves as a root criterion for those in standard 19.3.2. In other words its compliance score is derived from the aggregated average score of that section.

19.1.2.3 The responsibilities of this person include administrative supervision.

The manager is usually responsible for all administrative functions e.g. signing of leave forms, financial control, ordering of supplies, arranging servicing of equipment, etc.

Scoring of this criterion is based on evidence of implementation.

19.1.2.4 The responsibilities of this person include the monitoring and reviewing of all laboratory services.

This requirement links with 19.1.2.2 as well as all other criteria that require monitoring, review or evaluation of certain aspects of the service.

19.1.2.5 The responsibilities of this person include ordering and monitoring tests from outsourced laboratories.

19.1.2.6 The responsibilities of this person include the ordering of equipment and the development of an equipment maintenance plan.

19.1.3 Individuals with adequate training, skills, orientation and experience administer tests and interpret the results.

Standard Intent

The organisation identifies which laboratory personnel may perform testing and who may direct or supervise testing. Supervisory and technical personnel have appropriate and adequate training, experience and skills, and are oriented to their work. Technical personnel are given work assignments consistent with their training and experience. In addition, there are a sufficient number of personnel to perform tests promptly and to provide the necessary laboratory staffing during all hours of operation and for emergencies.

The organisation is able to identify and contact experts in specialised diagnostic areas, such as parasitology, cytology or virology, when needed.

19.1.3 Criteria

19.1.3.1 Those individuals, who may perform testing and those who may direct or supervise testing, are identified.

This criterion requires the availability of an organisational chart which reflects the persons required to provide an adequate service for the facility. However, where there are a number of vacant posts, this criterion can only be scored PC. The organisational chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criteria:
1.1.1.2, 1.2.7.2
2.2.1.1

19.1.3.2 Appropriately trained and experienced personnel perform tests.

19.1.3.3 Appropriately trained and experienced personnel interpret tests.

19.1.3.4 There is an adequate number of personnel to meet patient needs.

National requirements will apply and the hospital's organogram and staff establishment should be the basis for assessing such compliance. It is important to take note of any vacancies that may exist.

The compliance score of this criterion will inform the rating of 19.1.1.1.

19.1.3.5 A roster of experts for specialised diagnostic areas is maintained.

Please see statement of intent.

19.1.4 All laboratory equipment is regularly inspected, maintained, and calibrated, and appropriate records are maintained for those activities.

Standard Intent

Laboratory personnel work to ensure that all equipment functions at acceptable levels and in a manner that is safe to the operator(s). A laboratory equipment management programme provides for:

- selecting, acquiring and replacing equipment
- identifying and taking an inventory of equipment
- assessing equipment use through inspection, testing, calibration and maintenance
- the monitoring of and acting on equipment hazard notices, recalls, reportable incidents, problems and failures and
- documenting the management programme.

Testing, maintenance and calibration frequency are related to the laboratory's use of equipment and its documented history of service.

An individual is assigned responsibility for monitoring the temperature of the specimen fridge, which must be maintained between 2 and 6 degrees centigrade, and other fridges in the laboratory.

19.1.4 Criteria

19.1.4.1 There is a laboratory equipment management process.

Root criterion

Refer to the intent above for guidance on the different components that need to be included in such a programme. Although all these different components do not necessarily have to be included in a single "document", it is expected that the laboratory will have a "summarised" document that indicates "high-level" information or the main components such as regular/main/annual servicing of equipment, daily/weekly/monthly tests and checks to be done.

The implementation of the programme is measured in 19.1.4.7.and its compliance score needs to correlate with that of 19.1.4.1.

Linked criteria:
1.2.2.3
31.2.1.5

19.1.4.2 The process includes selecting, acquiring and replacing of equipment.

Documented evidence is required of the inclusion of these steps in the programme. This criterion may be scored NA in instances where these functions are performed at a higher level (regional/national/corporate head office).

19.1.4.3 The process includes taking an inventory of the equipment.

*Such an inventory should include all laboratory equipment as it serves as the basis for compiling the maintenance programme referred to above. Such inventory should be available in the laboratory even if 19.1.4.2 is scored NA for reasons stated***.**

Linked criterion:
3.1.1.8

19.1.4.4 The process includes the monitoring of environmental temperature at the prescribed level.

19.1.4.5 The process includes inspecting and testing the equipment.

19.1.4.6 The process includes calibrating and maintaining the equipment.

19.1.4.7 The process includes monitoring and follow-up of equipment maintenance.

Documented systems need to reflect on-going monitoring of equipment maintenance activities as stated above as well as any corrective actions taken when indicated by findings.

19.1.4.8 There is adequate documentation of all testing, maintenance and calibration of equipment.

Critical criterion

This criterion is scored NC if such documented evidence is lacking. This requirement links with the relevant afore-mentioned criteria (19.1.4.4 and 19.1.4.5) and these criteria should be scored PC if 19.1.4.7 is scored NC.

Linked criterion:
19.3.2.1

19.1.4.9 A named person is responsible for the specimen and reagent fridges.

Such designation should be evident in writing e.g. duty roster.

19.1.5 Essential reagents and other supplies are regularly available.

Standard Intent

The organisation has identified those reagents and supplies, necessary to regularly provide laboratory services to its patients. A process to order or secure those essential reagents and other supplies is effective. All reagents are stored and dispensed according to defined procedures. The periodic evaluation of all reagents ensures accuracy and precision of results. Written guidelines ensure the complete and accurate labeling of reagents and solutions.

19.1.5 Criteria

19.1.5.1 Essential reagents and supplies are identified.

Consider the level of service, the range of tests offered, and the type of equipment in use.

19.1.5.2 Essential reagents and supplies are available.

Linked criteria:
1.3.1.5
3.3.1.2

19.1.5.3 All reagents are stored and disposed of according to guidelines.

Documentation should be available in the form of policies, guidelines, safe work procedures and/or manufacturer's guidelines, against which the actual arrangements will be assessed. The assessment needs to include all storage areas such as fridges, cupboards, work stations and storerooms as well as the processes involved with the receiving, issuing and disposal of substances.

19.1.5.4 All reagents are periodically evaluated for accuracy and precision of results.

Service policies/procedures/protocols/guidelines should be available to guide this practice and assessment of compliance will be done against these. Records should be

available of such periodic evaluations performed on reagents, including water used in the laboratory.

Linked criterion:
19.3.2.1

19.1.5.5 All reagents and solutions are completely and accurately labelled.

Labelling requirements include identification, strength, storage requirements, date prepared or received and expiry date.

A random check needs to be done in all areas of the laboratory where these items are used and stored.

19.2 Management of Specimens and Results

19.2.1 Procedures for collecting, identifying, safely transporting and disposing of specimens are followed.

Standard Intent

Procedures are developed and implemented for the:

- ordering of tests
- collecting and identifying of specimens
- transporting, storing and preserving of specimens and
- receiving, logging in and tracking of specimens.

The procedures are observed for specimens sent to outside sources for testing, as well as for on-site laboratories.

Records are kept of when results have been telephoned, at what time and to whom.

19.2.1 Criteria

19.2.1.1 Request forms and specimen labels include unique patient identification and adequate supporting information.

This refers to the unique number allocated by the health facility and not the identity number allocated by the laboratory. (Refer to 19.2.1.3). Such numbering may be done manually or by means of bar coding. It is important to note that the patient's name alone is insufficient for such identification purposes.

The fact that a documentation audit process is undertaken to improve the poor quality of the completion of request forms does not warrant a compliant score.

Linked criterion
7.2.1.1
19.6.1.1

19.2.1.2 There is a collection and delivery service, for specimens from the organisation, daily.

This is measured against service policies and procedures.

Linked criterion:
1.2.7.2

19.2.1.3 Specimens are given a laboratory specimen number.

This can be done either manually or electronically.

19.2.1.4 Procedures guide the ordering of tests.

Arrangements are to be defined in policies and procedures. It should be ensured that these policies and procedures are available in the various clinical departments of the hospital.

19.2.1.5 Procedures guide the collection and identification of specimens.

19.2.1.6 Procedures guide the transport, storage and preservation of specimens.

19.2.1.7 Procedures guide receiving, logging-in and tracking specimens.

19.2.2 Established reference ranges are used to interpret and report clinical laboratory results.

Standard Intent

The laboratory establishes reference intervals or "normal" ranges for each test performed according to national/international standards. The range is included in the clinical record, either as part of the report or by including a current listing of such values, approved by the laboratory director/manager. Ranges are furnished, when an outside source performs the test. The reference ranges are appropriate to the organisation's patient population and are reviewed and updated, when methods change.

19.2.2 Criteria

19.2.2.1 The laboratory has national reference ranges for each test performed.

Such ranges will be determined by factors such as national arrangements, type of equipment, etc. In many instances these ranges may be determined at national or regional level in which instances this criterion will be scored NA with such explanatory comment.

19.2.2.2 The range is included in the clinical record at the time test results are reported.

19.2.2.3 Ranges are furnished when tests are performed by outside sources.

19.2.2.4 Ranges are reviewed and updated, as needed.

19.2.3 Policies and procedures regarding the reporting and reviewing of results are implemented.

19.2.3 Criteria

19.2.3.1 The organisation has established the expected turnaround time for results.

This aspect is policy-driven and documented evidence is required of such reporting times for the various tests. This information needs to be available in the various clinical departments, including outpatients and casualty/emergency departments.

Consultation with clinicians is important as the patient care aspects are included in the next criterion.

19.2.3.2 Laboratory results are reported within a time frame to meet patient needs.

Policy needs to define the process for informing clinical staff when delays are expected because of the impact this may have on patient care.

This criterion measures the adherence to the time frames stipulated in 19.1.1.4. It is recommended/required that the laboratory implements a monitoring system to assess whether the laboratory adheres to these times.

Linked criterion:
19.3.1.2

19.2.3.3 Emergency results may be obtained by telephone.

Critical criterion
These arrangements will be defined by service policies and procedures and records should be kept (either manually or electronically) with details of such calls name of laboratory personnel member, details of results, name of call receiver, date, time.

The call receiver must read back the test or result to confirm accuracy of information. The name of the staff member receiving the results must be documented by the laboratory. In private facilities, these names, times and dates are included in the final result form that goes to the ward/department.

Linked criteria:
7.2.2.1
19.1.1.4 and 5

19.2.3.4 Laboratory results are validated and include unique patient identity, date of testing/reporting, name and location of requesting physician.

19.2.3.5 The validating officer is identified and recorded.

19.2.3.6 There is a record of each test done, by whom, the result thereof, and a monthly summary.

This activity is policy driven and records with such details should be kept, either electronically or paper-based.

19.3 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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/co-ordinating quality improvement structures/ or systems. Departmental managers use available data and information to identify priority areas for 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.

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the temperature of the refrigerator over time, will be scored PC.

19.3.1 Criteria

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

Once the laboratory service has analysed its mission, defined its objectives, and identified all its stakeholders, there needs to be a way in which progress towards achieving these objectives can be measured.

The minimum requirement for considering compliance will be the availability of evidence of:

- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

19.3.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

Performance indicators are quantifiable measurements, determined beforehand, that will reflect the quality of the service or department.

Performance indicators could include:

- *turnaround times*
- *quality of specimens received e.g. leaking specimens*
- *correct tubes used*
- *correct completion of request forms*
- *the time between when the specimen was taken and the time that it actually reaches the laboratory.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

Regular measurements should be done to check on the performance indicators as above and these results will allow for on-going monitoring of either poor performance against the standards, or improvements over time. On-going monitoring is required in order to demonstrate that improvements are being sustained.

19.3.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.

Where the documentation (patient record) audit is a hospital wide multidisciplinary process, that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

These audit processes can include a documentation audit of request forms, the patient register, auditing of stock control record.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

19.3.1.5 An internal audit process for the laboratory services is implemented.

19.3.1.6 An external audit process for the laboratory services is implemented.

19.3.2 *There is a quality management plan for the execution of all laboratory quality control processes.*

Standard Intent

Sound quality control systems are essential to providing excellent pathology and clinical laboratory services. Quality control procedures include:

a) validation of the test methods used for accuracy, precision and reportable range
b) daily surveillance of results by qualified laboratory personnel
c) rapid corrective action when a deficiency is identified
d) testing of reagents
e) documentation of results and corrective actions.

Proficiency testing determines how well an individual laboratory's results compare with other laboratories that use the same methodologies. Such testing can identify performance problems not recognised by internal mechanisms. Thus, the laboratory participates in an approved proficiency testing programme when available. Alternatively, when approved programmes are not available, the laboratory exchanges samples with a laboratory in another organisation for purposes of peer comparison testing. The laboratory maintains a cumulative record of participation in a proficiency testing process. Proficiency testing, or an alternative, is carried out for all speciality laboratory programmes, when available.

19.3.2 Criteria

19.3.2.1 There is a quality control process for the clinical laboratory.

Root criterion
Linked criterion:
1.3.1.8

19.3.2.2 The processes include the validation of test methods.

19.3.2.3 The processes include the daily monitoring of test results.

19.3.2.4 The processes include the rapid correction of deficiencies.

19.3.2.5 The processes include the documentation of results, plus preventive and corrective actions.

19.3.2.6 The laboratory participates in a proficiency testing programme, or an alternative, for all speciality laboratory services and tests.

19.3.2.7 A cumulative record of participation is maintained.

19.3.2.8 The organisation regularly reviews quality control results from all outside sources of laboratory services.

Critical criterion
Linked criteria:
1.2.7.2
19.3.2.1

19.4 Patient Rights

19.4.1 *The department/service implements processes that support patient and family rights during care.*

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

19.4.1 Criteria

19.4.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation the policies will be evaluated during the patient record audits and patient interviews as well as by observation.
This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

19.4.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
4.1.1.6
5.2.1.1-3
6.1.2.1

19.4.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

19.5 Prevention and Control of Infection

19.5.1 *The department/service implements infection prevention and control processes.*

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

19.5.1 Criteria

19.5.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in the~~ir~~ department. Such documentation must form part of the organisation-wide infection control processes.

Examples of such risks include hand washing practices, cleaning and disinfection of equipment, wearing of protective clothing, exposure to aerosols, droplets, and needle stick injuries.

Linked criterion:
9.2.1.1

19.5.1.2 Individuals, who handle specimens, are trained in the proper handling of dangerous specimens.

Although it is expected that all laboratory staff would have received this training as part of their pre/post graduate training, systems and processes do change over time and compliance assessment will take into account the existence of current policies/procedures/protocols/guidelines and regular in-service training on these aspects.

19.6 Risk Management

19.6.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes.(Service Element 7).

19.6.1 Criteria

19.6.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial, and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

19.6.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

19.6.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

19.6.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

19.6.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 20 RADIOLOGY AND DIAGNOSTIC IMAGING SERVICE

OVERVIEW OF RADIOLOGY AND DIAGNOSTIC IMAGING SERVICE

The organisation is responsible for ensuring that the radiology and diagnostic imaging service meets the needs of its patient population, the clinical services offered, and the health providers.

These needs may be met within the organisation or may be outsourced. In either case, the radiology and diagnostic imaging service must comply with all applicable national standards, laws and regulations.

The organisational leaders ensure that where a radiology and diagnostic imaging service is provided by the facility there are radiation safety programmes in place and that individual with adequate training, skills, orientation and experience are available to undertake medical imaging procedures and interpret the results.

The radiology and diagnostic imaging service allows for immediate decision-making by practitioners through the provision of emergency services and the provision of emergency reports as necessary.

Standards

20.1 Management of the Service

20.1.1 *A radiology and diagnostic imaging service is provided by the organisation, or is readily available through arrangements with outside sources, to meet the needs of its patient population.*

Standard Intent

The organisation has a system for providing the radiology and diagnostic imaging services, required by its patient population, the clinical services offered, and health provider needs.

Radiology and diagnostic imaging services, including those required for emergencies, may be provided within the organisation, by agreement with another organisation, or both. The radiology and diagnostic imaging service is available after normal hours for emergencies.

Outside sources are convenient for the patient to access, and reports are received in a timely manner, which supports continuity of care. They are selected by the organisation on the recommendation of the director or another individual responsible for radiology and diagnostic imaging services. Outside sources of radiology and diagnostic imaging meet applicable laws and regulations and have an acceptable record of accurate, timely service. Patients are informed when the referring doctor owns the outside source of radiology and diagnostic imaging.

20.1.1 Criteria

20.1.1.1 An adequate, convenient and regular radiology and diagnostic imaging service is available to meet patient needs.

Root criterion that addresses a number of issues.

With "adequate" one should take into consideration the level of service that is required e.g. does the referral hospital provide a Computerized Axial Tomography (CAT) scan, is there a Radiologist, etc.

The service should meet the needs of the population that it serves e.g. if the service is only available 2 or 3 days per week, but the need is there for a daily service, then this would warrant a PC score.

If equipment is broken or supplies are lacking, or staff are inadequate and the full scope of service (as required) cannot be rendered then the criterion should be scored down.

"Convenient" refers to the patient's experience and it should be considered that sometimes patients are referred "unnecessarily" somewhere else because of staff shortage, broken equipment, lack of supplies, etc. Or they have to be admitted on Saturday to wait for X-rays on the Monday, in which case this criterion will be scored down.

"Regular" refers to the hours of operations and whether an after hour service is available or not this should be measured against the needs of the hospital and other clients that the radiology and diagnostic imaging service may serve, e.g. surrounding hospitals and clinics.

This would include the after-hour service. If there is no service available when required, this criterion will be scored PC.

Linked criteria:
1.2.7.2, 1.3.1.7
20.1.3.5
23.5.1.1

20.1.1.2 An emergency radiology and diagnostic imaging service are available after normal hours.

Policy needs to define the alternative arrangements to be in place should the on-site radiology and diagnostic imaging service not provide any after-hour service.

If there is no service available when required, this criterion will be scored NC.

Linked criteria:
2.2.1.5
22.7.1.1
24.7.1.1

20.1.1.3 The selection of an outside source is based on an acceptable record and compliance with applicable laws and regulations.

If the specific service is not available in the facility, and patients are referred to an outside source for specialised investigations, this criterion becomes applicable. In case of the latter there needs to be applicable documentation, either a Service Level Agreement (SLA), Memorandum of Understanding (MOU), contract or memorandum, which include documentation that this facility applies with the applicable laws and regulations.

Linked criterion:
1.2.7.2

20.1.1.4 Patients are informed about any relationships between the referring doctor and an outside source of radiology and diagnostic imaging service.

This does not generally apply to public institutions, where referral systems are dictated by policy. In that case, this criterion will be scored NA.

Wherever a patient is referred for diagnostic imaging services to another facility, the reason for this must be explained to the patient. Evidence of compliance will be sought during the ***patient record audit and patient interviews.***

In private facilities, where the referring medical practitioner has an arrangement to send patients to a particular facility, this must be brought to the attention of the patient, especially if the referral inconveniences the patient in any way.

Linked criterion:
1.2.5.1

20.1.2 A qualified individual is responsible for managing the radiology and diagnostic imaging service.

Standard Intent

The radiology and diagnostic imaging service is under the direction of an individual, who is qualified by virtue of documented training, expertise and experience, in accordance with applicable laws and regulations. This individual assumes professional responsibility for the radiology and diagnostic imaging service. When this individual provides clinical consultation or a medical opinion, he or she should be a doctor, preferably a radiologist.

The radiology and diagnostic imaging managers' responsibilities include:

- developing, implementing and maintaining policies and procedures
- administrative control
- maintaining any necessary quality control programmes
- recommending outside sources of radiology and diagnostic imaging services
- monitoring and reviewing all radiology and diagnostic imaging services.

20.1.2 Criteria

20.1.2.1 A registered radiologist or radiographer, who is appropriately experienced, manages the radiology and diagnostic imaging service.

National requirements need to be taken into consideration and the required evidence can be obtained from various sources such as post specifications, or job description. There should be evidence of registration with the relevant council.

Linked criteria:
1.3.1.1
2.2.1.1
2.5.1.1

20.1.2.1 The responsibilities of this person include developing, implementing and maintaining relevant policies and procedures.

Linked criteria:
1.2.6.1
20.2.2.1

20.1.2.2 The responsibilities of this person include administrative control.

The manager is usually responsible for all administrative functions e.g. signing of leave forms, financial control, ordering of supplies, arranging servicing of equipment, etc.

Scoring of this criterion is based on evidence of implementation.

20.1.2.3 The responsibilities of this person include maintaining quality control programmes.

This serves as a root criterion for those in standard 20.3.2. In other words its compliance score is derived from the aggregated average score of that section.

The initial commissioning tests need to be done by the supplier, and thereafter the routine tests need to be carried out by the licence holder or persons appointed by the licence holder.

The acceptance test must be submitted to the Radiation Protection Inspectorate (RPI). The RPI may carry out its own tests to verify the acceptance tests. Whenever a new unit is installed, the acceptance tests must be performed by the supplier.

With regards to regular monitoring, the minimum requirements would be monitoring of the processor, Entrance Skin Exposure (ESE) measurements on diagnostic units, DAP (Dose area product) measurements, radiation output repeatability, x-ray tube and generator checks accuracy, produce ability and MAS (milliAmpere seconds) linearity.

20.1.2.4 The responsibilities of this person include recommending outside sources of radiology and diagnostic imaging services.

See comments for criteria 20.1.1.3 and 4

20.1.2.5 The responsibilities of this person include monitoring and reviewing all radiology and diagnostic imaging services.

Monitoring systems to review the service provided should be implemented. These can include regular staff meetings, patient satisfaction questionnaires, stock control, the monitoring of waiting times and should also include the quality control and radiation safety aspects as referred to in 20.1.2.4 above.

20.1.3 Individuals with adequate training, skills and experience perform diagnostic imaging procedures and interpret the results.

Standard Intent

The organisation identifies those personnel who may perform procedures and those, who may interpret X-ray films and report the findings.

These staff members have appropriate and adequate training, experience and skills, and are oriented to their work. Radiographers are given assignments consistent with their training and experience. There are sufficient personnel to provide necessary staffing during all hours of operation and for emergencies.

The organisation is able to identify and contact experts in specialised diagnostic areas such as radiation physics, radiation oncology, or nuclear medicine, when the need for such services arises. The organisation maintains a roster of such experts.

20.1.3 Criteria

20.1.3.1 Those individuals, who may perform diagnostic imaging procedures and those, who may interpret and report the results are identified.

This criterion requires the availability of an organisational chart which reflects the persons required to provide an adequate service for the facility. However, where there are a number of vacant posts, this criterion can only be scored PC. The organisational chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Performing of X-rays:
National arrangements will apply.
The following persons may perform radiological examinations: radiologists, radiographers, medical doctors, dentists, authorised and registered as per registration requirements.

In most cases hospital policy does not allow for anybody other than the first three categories (radiologists, radiographers and supplementary radiographers) to perform X-rays.

Interpret/report results: National arrangements will apply. Only radiologists and medical doctors can perform this function. If no radiologist is available in the department, interpretation of the X-rays will be done in the ward and the interpretation should be recorded in the patient's record. If a radiologist is available, formal reporting will be done in the department by the radiologist.

Linked criteria:
1.1.1.2, 1.2.7.2
2.2.1.1

20.1.3.2 A mechanism exists, which ensures that procedures are performed only by radiographers, radiologists, or specially trained doctors and other persons, authorised to do so by a health professions council

Critical criterion
Medical Imaging practisioners that are registered with professional councils are allowed to perform X-rays, ***in medical diagnostic imaging***

20.1.3.3 X-rays are done only upon a signed request from a qualified authorised health practitioner.

National requirements will apply, X- Ray examinations may only be requested by a medical practitioner, a dentist or any other appropriately trained and registered health professional.

In most cases hospital policy does not allow for anybody other than radiologists, radiographers and supplementary radiographers to perform X-rays.

Where medical practitioners sign blank forms in advance this criterion will be scored NC.

20.1.3.4 X-rays are interpreted and reported on by appropriately trained and experienced staff.

The difference between interpretation and reporting should be noted. A medical practitioner interprets X-rays and should document his/her findings in the patient's record. Radiologists formally report on X-rays. Trained radiographers and sonographers can also report on X-rays.

Linked criterion:
20.1.3.1

20.1.3.5 There is an adequate number of staff to meet patient needs.

This should be measured against the current staff establishment as well as the departmental arrangements, as discussed in criteria 20.1.1.1 and 2.

20.1.3.6 Experts in specialised diagnostic areas are contacted, when needed.

Although the statement of intent states "contact experts in specialised diagnostic areas such as radiation physics, radiation oncology, or nuclear medicine, when the need for such services arises", other investigations can also be considered to be of a specialised nature,e.g. barium studies, IVP's, fluoroscopic investigations, etc. and can be included under this criterion.

Linked criterion:
1.2.7.2

20.1.3.7 A roster of experts for specialised diagnostic areas is maintained.

This criterion is linked with the previous one (20.1.3.6) requesting a roster of these experts and contact details of these experts.

20.2 Reporting and Recording

20.2.1 Reporting and recording policies and procedures within the radiology and diagnostic imaging service ensure safety and legality.

Standard Intent

X-ray request forms and the ensuing reports must identify the correct patient and the correct site of X-ray. The organisation defines the time period for reporting diagnostic radiology and diagnostic imaging test results. Results are reported within a time frame based on patients' needs, services offered, and clinical staff's needs. Mechanisms are in place to ensure that X-ray results are reported on immediately in an emergency.

The X-ray films are the property of the patient, and may be taken away by the patient. Where this is done, he/she must be told to bring the films along at future visits. Where the organisation stores films, these are kept for a minimum of three years or longer as defined by organisational policy.

20.2.1 Criteria

20.2.1.1 X-ray request forms contain the date of the request, patient's name, examination requested, relevant previous examinations and investigations, name of the requesting officer and clinical information to explain the request.

Critical criterion

The above details should be provided when an X-ray is requested. Some aspects are usually not included in the completed form, which will usually warrant a PC score by default.

Linked criterion:
20.6.1.1

20.2.1.2 The organisation has established the expected turnaround time for results.

This criterion should only apply where the services of a radiologist are utilised.

If formal reporting by a radiologist is done, a policy needs to be available to define the time period within which the reporting will be done. Reports are often not done for all X-Ray examinations.

20.2.1.3 Radiology and diagnostic imaging results are reported on within a time frame to meet patient needs.

This criterion is linked to the previous one and requires that a formal monitoring mechanism is implemented, if reporting is done by a radiologist.

Linked criterion:
20.3.1.2

20.2.1.4 There is a method of checking the X-ray reports against the clinical records.

20.2.1.5 X-ray reports contain a clear conclusion (including recommendations for future treatment if appropriate).

20.2.1.6 A copy of the report is filed in the patient's record.

This criterion is only applicable in cases where reporting is done by a Radiologist

In the case where there is no Radiologist, the expectation is that the treating doctor will record his/her interpretation of the film ***in the patient's clinical notes****.*

20.2.1.7 Films are available at each visit of the patient.

A system needs to be in place for the movement of films throughout the organisation, to ensure their eventual return to the Radiology department.

In the private sector, X-rays are the property of the patient, who is responsible for bringing them to consultations. ***In some instances****, the patient is given a CD and the radiology service retains an electronic copy.*

20.2.1.8 A policy that defines the length and method of storage of X-ray films is implemented.

National arrangements will apply.

20.2.1.9 Where patients are allowed to take films home, education on proper storage must be provided.

20.2.2 The radiology and diagnostic imaging service meets applicable national standards, laws and regulations.

Standard Intent

The organisation ensures that staff is knowledgeable about the relevant legal requirements relating to radiology and diagnostic imaging. This is ensured, by having available copies of the most recent radiation safety report and local rules, relating to current Ionising Radiation regulations, and other applicable documents, which provide guidance relating to legality.

The organisation satisfies the statutory requirements under the Ionising Radiation regulations, according to the most recent radiation safety report.

There are organisational arrangements, which allow for advice on radiation protection and how to deal with a suspected case of overexposure.

20.2.2 Criteria

20.2.2.1 Written policies and procedures that address compliance with applicable standards, laws and regulations are implemented.

Root criterion

Policies and procedures should include at least the following:

- *The qualifications of staff*
- *Radiation safety, including radiation safety inspections, signage in the department, the handling and disposal of hazardous material, over-exposure, the wearing of dosimeters, etc.*
- *X-rays of pregnant women*
- *Requesting X-rays*
- *Reporting on films including the time frames for reporting*
- *The availability of emergency drugs and equipment.*

Linked criteria:
1.2.1.4, 1.2.1.5
20.1.2.2
20.6.1.1

20.2.2.2 A copy of the national rules relating to current ionising Radiation regulations is available e.

National regulations will apply and will include:

- *A copy of the Radiation Protection Act and Regulations*
- *Relevant guidelines and policies from the Radiation Protection Inspectorate.*

20.2.2.3 A copy of the most recent radiation safety report is held.

Critical Criterion

In the case of new units, Radiation Control do not necessarily perform an inspection (the only exception is radiotherapy), but they base their decision whether to issue a licence on the QA (quality assurance) results of the supplier. Therefore, in the case of new units, one should make it compulsory for the hospital to produce the QA results from the supplier.

Previously a routine 3-5 yearly visit to all Radiology Units was done and this occasionally still happens. In cases where there is no evidence of a recent visit (1-3 years) by the Radiation Protection Inspectorate, this criterion will be scored on documented evidence of the continuation with the internal QC (quality control) tests (processing conditions, darkroom fog, screen film contact, reject analysis, etc.) and annual equipment maintenance (which covers the radiation safety aspects).

20.2.2.4 The organisation satisfies the statutory requirements under the Ionising Radiation regulations.

Critical criterion

This criterion is linked with the one above (20.1.4.3). Documented evidence should be available that the deficiencies identified in the above-mentioned report have been addressed. The licence holder normally has 21 days to implement the requirements from Radiation Control Protection Inspectorate after their inspection, unless they can show proof why they are not in a position to do so.

20.2.2.5 A Radiation safety officer(RSO) is identified and available to assist a radiation protection inspector in complying with the ionising Radiation regulations.

National arrangements will apply, but the following will be required:

At hospital level there should be a responsible person whose name appears on the licensing documentation from the RPI (Radiation Protection Inspectorate)as the "license holder/responsible person" who is normally the Owner or the head of the hospital facility. The licence appoints a person experienced and qualified in radiation safety as RSO (Registered Safety Officer).

***Medical Physicists**" is a person at a higher level, for instance at National level, who can be contacted in case of problems/enquiries.*

20.2.2.6 A patient register is available in the radiology and diagnostic imaging department.

A patient register/index should be available in the department. This can be in the form of a register or an electronic system. If an electronic system is used, adequate arrangements for back-up of data should be in place.

20.2.3 X-ray film and other supplies are regularly available.

Standard Intent

The organisation has identified the quantities of film, reagents and supplies necessary to provide a radiology and diagnostic imaging service to its patients. A process to order or secure essential film, reagents and other supplies is effective. All supplies are stored and dispensed, according to defined procedures. The periodic evaluation of reagents ensures accuracy and precision of results. Written guidelines ensure the complete and accurate labelling of film, reagents and solutions.

20.2.3 Criteria

20.2.3.1 Essential quantities of film, reagents and supplies are available.

It should be noted that some departments are using the digital format. Not all films will therefore be printed. Reagents are not used for digital format. Relevant departments will be digitally connected. Arrangements need to be in place in case the digital system fails. Manual backup systems should be in place in case of failure of the digital system.

As far as "supplies" are concerned, one should not lose sight of the "investigational medicines" referred to in SE 21, as often the Radiology department order these directly without the involvement of the Pharmacy.

Linked criterion:
1.3.1.5
3.3.1.2
21.3.1.1

20.2.3.2 All film and reagents are stored and disposed of, according to guidelines.

<u>Storage</u>:
The correct storage of unexposed films is important. Unexposed and unprocessed x-ray films should always be kept in a cool, dry place. The boxes should be stored in an upright position, off the floor, not exposed to direct sun-light. It should never be stored in basements or near steam pipes or other sources of heat. In extremely warm climates, only small quantities of films should be ordered at one time, so that a rapid turnover takes place. High temperatures damage the emulsion, causing fog and lack of contrast. An unexposed x-ray film is not usable after a few weeks when it has been subjected to temperatures of 32ºC to 38ºC. The recommended storage temperature is 10 to 20°C and properly shielded from X-rays, gamma rays, or other penetrating radiation.

<u>Disposal:</u>
A contract with a company for silver recovery is usually available. Observe storage conditions prior to removal. The practice whereby used reagents are poured down the sewerage system must be discouraged.

Linked criteria:
1.2.7.2
7.7.1.1
20.6.1.1

20.2.3.3 All reagents and solutions are completely and accurately labelled.

20.3 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (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 the managers to ensure that standards are set for the particular department. This requires Coordination with the organisation's central/management/co-ordinating quality improvement structures or systems.. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) request forms without history or clinical diagnosis
b) number of unidentified patients
c) unescorted patients arriving at the department
d) waiting times
e) reject analysis and remedial action taken
f) patient and family expectations and satisfaction.

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 problem
- 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 tables results, as appropriate.

A once off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

20.3.1 Criteria

20.3.1.1 There are formalised quality improvement processes for the service, which has been developed and agreed upon by the personnel of the service.

Once the radiology and diagnostic imaging service has analysed its mission, defined its objectives, and identified all its stakeholders, there needs to be a way in which progress towards achieving these objectives can be measured.

The minimum requirement for considering compliance will be the availability of evidence of:

- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

20.3.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

Performance indicators are quantifiable measurements, determined beforehand, that will reflect the quality of the service or department.
Performance indicators could include:

- *turnaround times*
- *correct completion of request forms*

The quality improvement programme should also concentrate on the deficiencies outlined in the routine quality assurance inspections, but especially attempts that are made to minimise the radiation dose to the patient. This latter aspect is receiving much attention at the moment, viz. the issue of diagnostic reference levels (DRL's).

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

Linked criterion:
20.2.1.4

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

Regular measurements should be done to check on the performance indicators as above and these results will allow for on-going monitoring of either poor performance against the standards, or improvements over time. On-going monitoring is required in order to demonstrate that improvements are being sustained.

20.3.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.
Where the documentation audit is a hospital wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

These audit processes can include a documentation audit of X-Ray request forms, the patient register, X-ray envelopes, auditing of stock control records, etc.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

20.3.2 Quality control procedures are in place, followed and documented.

Standard Intent

Sound quality control systems are essential to providing excellent radiology and diagnostic imaging services. Quality control procedures include:

a) validation of the test methods used for accuracy and precision
b) daily surveillance of imaging results by qualified radiology staff
c) rapid corrective action when a deficiency is identified
d) testing of reagents and solutions
e) documentation of results and corrective actions.

20.3.2 Criteria

20.3.2.1 There is a quality control process for the radiology and diagnostic imaging service and it is implemented.

Root criterion

International list of acceptance and routine quality control tests is available on the website of the Department of Health
http://www.doh.gov.za/department/radiation/01.html.

Linked criteria:
1.3.1.8
8.2.2.1

20.3.2.2 Quality control includes validating test methods.

20.3.2.3 Quality control includes daily surveillance of imaging results.

20.3.2.4 Quality control includes rapid correction when a deficiency is identified.

20.3.2.5 Quality control includes equipment maintenance/testing/safety.

20.3.2.6 Quality control includes documenting results and corrective actions.

Critical criterion
Linked criterion:
20.3.2.1

20.4 Patient Rights

20.4.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

20.4.1 Criteria

20.4.1.1 There are processes, which support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. The implementation thereof will be evaluated during the auditing of patient records, patient interviews and observation in the department.
This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

20.4.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Special emphasis should be placed that privacy is maintained at all times; especially during dressing/undressing, walking to the treatment room in front of other patients, etc.

Linked criteria:
4.1.1.6
5.2.1.1-3
6.1.2.1

20.4.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

20.5 Prevention and Control of Infection

20.5.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

20.5.1 Criteria

20.5.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide infection control programme.

A number of aspects need attention in this department, i.e. availability of linen and gowns; infection control measures to be implemented during invasive procedures; the use of masks if patients are on oxygen, etc. One should also consider whether these aspects are catered for in the overall infection control programme.

Other aspects to include are the general housekeeping practices (cleaning of the department, hand washing aspects, cleaning of equipment including sonar probes, etc.).

Linked criterion:
9.2.1.1

20.5.1.2 Infection control processes include prevention of the spread of respiratory tract infections, and focuses on processes that may lead to infection.

20.5.1.3 Infection control processes include prevention of the spread of skin infections, and focuses on processes that may lead to infection.

20.5.1.4 Infection control processes include prevention of the spread of infection through intravascular invasive devices.

20.6 Risk Management

20.6.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

The organisation has an active radiation safety programme that includes all components of the organisation's radiology and diagnostic imaging services, including radiation oncology and the cardiac catheterisation laboratory. The radiation safety programme reflects the risks and hazards encountered. The programme addresses safety practices and prevention measures for radiology and diagnostic imaging staff, other staff and patients.

The programme is co-ordinated with the organisation's safety management programme.

20.6.1 Criteria

20.6.1.1 The department conducts on-going monitoring of risks through documented assessments as part of the organisational programme.

Root criterion

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor related risks, financial, and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criteria:
7.1.1.1
20.2.2.1

20.6.1.2 Appropriate radiation safety devices are available.

Radiation warning signs must be displayed at the entrances of all the X-ray rooms and should be easily visible.

Warning lights are required at the entrances to fluoroscopy and CT rooms.
Lead aprons/gonad shields/etc. should be available. Access doors should be lead-lined.

Dosimeter badges should be available for all radiation workers. Even if all the above safety devices are available and dosimeter badges are not available, this criterion will be scored as PC.

20.6.1.3 Dosimeter badges are worn and handled according to Ionising Radiation Regulations.

Critical criterion

The register for radiation workers needs to be available and up to date. Every registered radiation worker should be supplied with a dosimeter. This dosimeter shall be replaced monthly, unless a radiation occurrence is suspected or has been established.

All full-time theatre personnel must be monitored. In cases where the workload is very low e.g. every three to four months, these staff members may be exempted from being

monitored. A file should be available with dosimeter reading reports for all registered persons.

Linked criterion:
20.2.2.1

20.6.1.4 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

20.6.1.5 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criteria:
7.4.1.4

20.6.1.6 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.
Linked criterion:
7.5.1.1

20.6.1.7 Organisation policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated during the walk-about through the department. The process must include handling at source, collection, storage and disposal of all waste, including radiological waste. Specific focus will be placed on the recovery of silver in the conventional units, and documented evidence that the radiology equipment (tubes, etc.) has been condemned with approval from Radiation Control, or equivalent.
The practice whereby used reagents are poured down the sewerage system in some countries needs ministerial intervention in some case. Where patients have taken radiographic film home they may be advised to return them to the hospital for safe disposal.
The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.
Linked criterion:
7.7.1.1

SE 21 PHARMACEUTICAL SERVICE

OVERVIEW OF THE PHARMACEUTICAL SERVICE

A health organisation must ensure that appropriate medications are available and dispensed to meet the needs of the patient population. Appropriately qualified and experienced pharmacy staff ensures that the pharmaceutical service and medication use comply with applicable laws and regulations. Systems ensure that medications are safely stored and maintained.

The prescribing, ordering, storage, handling, dispensing, preparation and administration of medications are guided by policies and procedures, which are known to and implemented by the organisation's staff. The organization ensures that only qualified individuals are permitted to prescribe medications and permitted to administer medications.

Pharmacists ensure collaboration with all other relevant departments, where medications are used and stored. Systems are available to ensure, that those who are not registered pharmacists, are supervised and practice in accordance with current national laws and regulations.

Standards

21.1 Management of the Service

21.1.1. Medication management is organised throughout the organisation, to meet the needs of patients.

Standard Intent

As an important resource in patient care, medication use must be organised effectively and efficiently throughout a health organisation. Medication management is not only the responsibility of the pharmaceutical service but also of the managers and clinical care providers. How this responsibility is shared depends on the organisation's structure and staffing. In those facilities where there is no pharmacy medications should be managed as per the requirements of the law. In facilities, where there is a large central pharmacy, the pharmacy should organise and control medications throughout the organisation. Applicable laws and regulations are incorporated into the organisational structure and the operations of the medication management system used in the organisation.

A registered pharmacist, who is qualified by education, training and experience, directly supervises the activities of the pharmacy or pharmaceutical service.

Documentation, which guides the management of the service, is available and consulted, e.g.:

- current national acts and regulations, relating to medication control guidelines, relating to professional practice.

21.1.1 Criteria

21.1.1.1 A registered pharmacist with clearly defined responsibilities and accountabilities is designated to manage all aspects of the pharmaceutical service.

This refers to a person appointed to the management position in terms of the job specifications.

Where pharmacy technicians or similar individuals are employed, National laws and regulations will apply.

This criterion will be scored as PC if:
- there is no documented job description or job specification and
- the position is filled by someone in an acting capacity.

In the case where an unqualified person manages the service, the score will be NC.

Linked criteria:
1.3.1.1
2.2.1.1, 2.5.1.1

21.1.1.2 A registered pharmacist is appointed to act in the absence of the manager.

The appointment must be documented.

The situation occurs sometimes in small hospitals that only one pharmacist is available and the matron or other another person takes charge of the pharmacy in the absence of the pharmacist. In this case the criterion will be scored NC.

Linked criteria:
1.3.1.1
2.2.1.1, 2.5.1.1

21.1.1.3 The responsibilities of the pharmacy manager include ensuring compliance with laws, regulations and professional guidelines relating to the service.

It is important to note that this criterion can only be scored after all the services where medication is managed have been assessed.

The hospital pharmacy should be included in the hospital licence. If run privately it would be licensed under the Medicines and Related substances Act.

The manager (Pharmacist) will be registered with the health professions council.

This criterion will be scored compliant by default, but a PC rating is given whenever there is actual evidence of non-adherence to any particular legal requirement.

Linked criteria:
1.2.1.4
1.2.6.1
2.3.1.1

21.1.1.4 The responsibilities of the pharmacy manager include ensuring compliance with pharmacy practice and current pharmaceutical and other health professional guidelines, e.g. medical and nursing.

National laws, regulations and professional arrangements will apply.

Examples of such laws, regulations and professional guidelines are:
- *Medicines and Related Substances Act*
- *National Drug Policy*
- *List of Drugs Allowed In The Country*
- *Pharmacy Practice standards*
- *Treatment Guidelines and*
- *Current medicine formularies/essential medicines list*
- *Professional guidelines for doctors and nurses, with regard to all aspects pertaining to medication management.*

21.1.1.5 There is an adequate number of staff available to meet patient needs during working hours and after hours.

21.1.2 The pharmaceutical service is co-ordinated with other related services in the organisation.

Standard Intent

The pharmaceutical service works with all other departments in the organisation to ensure safe medication usage and control, and to limit adverse drug reactions.

This communication is provided through committee meetings, such as those of the Drugs and Therapeutic Committee, Pharmacovigilance Committee and the Drug Information and Toxicology Office. Minutes of these meetings are circulated to all relevant departments.

Pharmaceutical staff works with other professional staff to identify their needs for in-service training and provide such training as part of the organisation's in-service training programme.

Pharmacists visit wards and departments on regular basis to check prescriptions, administration records, and storage and control of medicines.

21.1.2 Criteria

21.1.2.1 Collaboration exists between the pharmacy staff and other relevant staff in the organisation to ensure safe prescribing, ordering, storage, preparation, dispensing and administration of medicines.

The formulation of medication related policies and procedures should be seen as part of this collaboration, as well as the provision of drug information to all health professionals, which could include:

- *New medicines, withdrawal/availability, alternatives, generics*
- *Drug utilisation report, changes in usage patterns, out of stock items*
- *Interactions, adverse reaction reports*
- *Results from quality monitoring processes such as medication errors, antibiotic usage, expired stock, aged stock, etc.*

Linked criteria:
1.2.8.1
10.6.1.1, 10.6.2.4as well as related criteria in all in-patient services.
21.3.1.1, 21.6.1.2
22.9.1.1
23.7.1.1
24.9.1.1

21.1.2.2 The organisation defines the requirements of a complete order or prescription, taking relevant legal specifications into account.

National laws and regulations will apply, for example Medicines and Related Substances Act.

This refers to the policies and procedures as required in standards 21.3.1.
Linked criteria:
10.6.1.1 as well as related criteria in all in-patient services.
21.3.1.1

22.9.1.1
23.7.1.1
24.9.1.1

21.2 Access to Appropriate Medication

21.2.1 *An appropriate selection of medications for prescribing or ordering is stocked or readily available.*

Standard Intent

Every organisation must decide which medications to make available for prescribing and ordering by the care providers. This decision is based on the organisation's mission, patient needs, and the types of services provided. The organisation develops a list of all the medications based on the laws and regulations of the country. Medication selection is a collaborative process, which considers patient need and safety as well as economics. The organisation has a method, such as a committee, to maintain and monitor this medication list and to monitor the use of medication within the organisation. An in-stock list is produced periodically.

Management of medication use in an organisation requires an understanding of the sources and uses of medications, which are not prescribed or ordered within the organisation.

On occasion, medications not readily available to the organisation are needed. There are also occasions where medications are needed at times when pharmacies are closed. Each organisation needs to plan for these occurrences and to educate staff on the procedures to follow should they occur. When patient emergencies occur, quick access to appropriate emergency medications is critical. Each organisation plans the location of emergency medications, and the medications to be supplied in these locations. To ensure access to emergency medications when needed, the organisation establishes a procedure or process to prevent theft or loss of the medications, and to ensure that medications are replaced when used, or when damaged or out of date. Each organisation also needs to determine its role in providing medications to patients at discharge. Those who prescribe or order medication know what medications, if any, are available and how to obtain them.

21.2.1 Criteria

21.2.1.1 Medicines appropriate for the organisation's mission, patient needs and services provided are available for prescribing.

Stock levels will be dependent on the amount used and the reliability of deliveries from suppliers.

The scoring will depend on the availability and appropriateness of medicines to be able to treat all conditions relevant to the level of care.

In private hospitals, private buying contracts and medical aid directives provide a guide, but the final decision still remains with the doctor what he/she prefers to prescribe.

Linked criteria:

1.3.1.5
4.1.1.9

21.2.1.2 There is a list of medicines stocked in the organisation or readily available from outside sources.

21.2.1.3 There is a method for control of medication use within the organisation.

This criterion covers a number of aspects.

This includes all stock control measures reasonably expected to be in place and also includes the authorisation to prescribe and dispense.

Examples are: Drug utilisation reviews, adhering to protocols, use of specialised drugs, control of ward stock, and other control mechanisms. For example: secure movement of medication through the hospital, signature for the receipt of medication, control of the after-hour cupboard, prescription patterns by doctors (such as poly-pharmacy).

Linked criteria:
21.3.1.1

21.2.1.4 There is a process to obtain required medicines not stocked or normally available to the organisation.

At government hospitals there is usually a clearly defined process guided by a governmental pharmaceutical supply policy framework.

In the private sector there should be a documented directive/policy available. This is often a reciprocal arrangement with other pharmacies or hospitals and can be verified by requesting records of relevant communications between concerned parties.

21.2.1.5 There is a process to obtain required medicines, when the pharmacy is closed.

Three systems should be considered:
- *the after hour cupboard from which wards can replenish via the night duty supervisor*
- *the "to take out" (TTO) cupboard often located in casualty from where TTO/stat doses are issued/dispensed/administered after hours*
- *on call arrangements by the pharmacists or pharmacy personnel should also be in place.*

It is important to assess if the operational arrangements/policy framework is in line with the national legal framework. It is also important that the policy framework states clearly the documentation to be completed in this process to ensure on-going medication control.

Linked criteria:
15.6.1.1
22.9.1.2
24.9.1.2

21.2.1.6 Emergency medicines are available in the organisation within a time frame to meet emergency needs.

This criterion refers to the identification of emergency medications and their *availability. Emergency medication includes medication on the emergency trolleys, an after-hour cupboard/room, poison antidotes, medication in theatre, etc.*

Personnel need to be made aware where all of these medications are kept and how to obtain it.
The organisation needs to assess the poison risks in the population served. This could include organophosphate poisoning, dog, scorpion and/or snake bites. There should be telephone/internet links to a poison centre and the number should be easily accessible.

The time frame is measured in an indirect manner i.e. assess the availability according to organisational checklists (e.g. emergency trolleys), medicine lists (e.g. after hour cupboards) and out of stock reports.

Linked criteria'
15.6.1.1
22.9.1.2
24.9.1.2

21.2.1.7 Emergency medicines are monitored and replaced in a timely manner, after use or when expired or damaged.

This criterion refers to the availability as well as expiry dates of emergency medication and does not only refer to the monitoring of the resuscitation trolley but to all the other areas as listed in 21.2.1.6.

Linked criteria:
10.6.3.9as well as related criteria in all in-patient services
22.9.3.9
23.7.3.9
24.9.3.9
30.2.1.3

21.2.1.8 Policies and procedures related to the handling of expired medicines are implemented throughout the organisation.

21.3 Policies and Procedures

21.3.1 *There is a collaborative effort to develop and monitor policies and procedures for the pharmaceutical service.*

Standard Intent

Safe pharmaceutical practices are guided by laws and regulations as well as organisational policies and procedures. Medical, nursing, pharmacy and administrative staff participate in a collaborative process to develop and monitor the policies and procedures.

The clinical and managerial leaders use a collaborative process to develop policies

and procedures and training staff in their implementation.

Of particular concern is that the policies or procedures identify:

- how planning will occur
- the documentation required for the care team to work effectively
- special consent considerations e.g. trial medicines
- monitoring requirements
- special qualifications or skills of staff involved in the care process
- availability and use of resuscitation medicines.

Clinical guidelines are frequently helpful and may be incorporated in the process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high risk procedures e.g.

a) safe storage, prescribing, ordering, dispensing, transcribing and administration of medications in the organisation.

National laws and regulations will apply. e.g. registered nurses are not permitted to prescribe medication in a hospital setting or transcribe doctors' prescriptions.

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

b) Documentation requirements

This may be specified in the above-mentioned policy or implied by the provision of specific forms, books, registers, reports, etc.

c) keeping at least three months of buffer stock

d) use of verbal medication orders

The procedure to be followed must be clearly documented in line with current legislation and must be implemented.

It is important to note that the policy requirement is stated in this service element, yet the implementation is measured under risk management standard 7.2.1 and in all the clinical service elements e.g. 10.6.1.2and others.

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

e) availability and use of medication samples

A policy framework must be available even if samples are not accepted by the facility.

f) documentation and management of any medications brought into the organisation for or by the patient

The policy needs to clearly state what procedure needs to be followed in case a patient brings his/her medication to the hospital. It is important that the medical practitioner is aware of what medication the patient is using.

Medications (including traditional, over-the-counter and homeopathic medicines) brought into the organisation must be recorded in the patient record.

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

g) self-administration of medication by the patient

National laws and regulations will apply.
If this practice is allowed, storage of medication in the ward must comply with hospital and legal requirements. Medications must be secure from access by other patients.

Self-administration of medication maybe part of the discharge planning process in rehabilitation wards. It can also be a strategy that can be undertaken on selected patients in other wards.

Patients considered appropriate and safe by their multi-disciplinary team may self administer prior to discharge.

h) dispensing of medications at the time of the patient's discharge

i) preparation, handling, storage and distribution of parenteral and enteral nutrition products

The development of this policy should also be of a multi-disciplinary nature (Clinician, pharmacist, nurse and dietician). If these feeds are prepared at the hospital, an aseptic technique should be followed. If there is no preparation on site, there must still be a policy guiding the handling, storage and distribution when products are ordered from outside suppliers.

j) Storage, handling, distribution and dispensing of controlled, high-alert and hazardous medications

National laws and regulations will apply.

Hazardous medications may include cytotoxics, warfarin, methotrexate, concentrated electrolytes, opiates, barbiturates, etc. Specific prescribed facilities maybe required for the handling of certain hazardous substances such as radioactive pharmaceuticals.

k) Storage, handling, distribution and dispensing of investigational medications

Investigational medications in this context refer to contrast media used for specialised radiological examinations e.g. barium, etc. This policy need to be developed in conjunction with the Radiology Department.

This criterion maybe scored NA if the Diagnostic Imaging Services manage their own contrast media. See criterion 20.2.3.1

l) Management of medications, used in clinical trials

Refer to criterion1.2.3.8. If clinical trials are conducted, specific guidelines with regard to the management of the medication used in the trial should be available. Usually the decision about storage and administration is taken by the pharmacist, the Medical Manager and the Principal Investigator.

m) Security of staff, equipment and stock

Refer to standards 21.5.1 and 7.4.1

n) management of adverse drug reactions

o) management of medication errors

p) management of expired medicines.

21.3.1 Criteria

21.3.1.1 Policies and procedures, which include at least those from a) to o) in the intent above, are developed and implemented.

Root criterion *for all medication related policies and procedures in SE 21.*

Linked criteria:
1.2.1.4, 1.2.6.1, 1.2.6.6, 1.3.2.1
7.2.2.1, 7.2.3.1
10.6.1.1, 10.6.1.4, 10.6.2.3, 10.7.1.5as well as all related criteria in all clinical services
20.2.3.1
21.1.2.1-2, 21.2.1.3
22.9.1.1
23.7.1.1
24.9.1.1

21.3.1.2 There is evidence that policies and procedures have been developed collaboratively with all relevant departments.

21.4 Dispensing of Medicines

21.4.1 Dispensing of medications adheres to laws, regulations and professional standards of practice.

Standard Intent

A registered pharmacist reviews each prescription or order for medication. When questions arise, the individual who prescribed or ordered the medication is contacted.

The dispenser signs the prescription. When pharmacist assistants/technicians or interns dispense, they are supervised, and their signatures, as dispensers, are countersigned by a registered pharmacist.

The organisation dispenses medications in the most ready-to-administer form possible, to minimise opportunities for error during distribution and administration. The central pharmacy and other medication distribution points throughout the organisation use the same system. The system supports accurate dispensing of medications in a timely manner.

It is generally accepted that the dispensing process is divided into 3 phases:
Phase 1: Interpretation and evaluation of a prescription
Phase 2: Preparation and labelling
Phase 3: Provision of information and instructions to the patient

These 3 phases may be performed by a pharmacist or a pharmacist technician under the direct supervision of a pharmacist. Other cadres can dispense (medicine) as per the provisions of the Medicines and Related Substances Act of 2013 and Regulations thereof."

21.4.1 Criteria

21.4.1.1 Medicines are prepared and dispensed in a safe and clean environment.

This refers to the use of the required personal protective equipment and the availability of appropriate facilities for the various types of functions performed. Attention to be given when specialised functions are performed. For example: The preparation of total parenteral nutrition, sterile compounding the preparation of cytotoxic medication, etc.

21.4.1.2 There is a uniform medication dispensing and distribution system in the organisation.

Where satellite pharmacies/distribution points e.g. emergency/ after hours cupboards exists, uniform processes are applied.

Distribution will also include the delivery methods to patient care areas in the hospital. Dispensing for to be discharged patients must be included in the system.

It is important to note that the way in which dispensing/issuing is done after hours may affect the score if it does not conform to the same rules as day time practice.

Linked criteria:
15.6.1.1
22.9.1.1
24.9.1.1

21.4.1.3 The system supports accurate and timely dispensing.

In order to measure compliance the pharmacy/hospital will have to provide data on the monitoring of waiting times (for both out patients and discharged inpatients) and dispensing errors.

In the absence of such data a judgement call might be required by observing queues, movement of patients in the outpatient department and assessing the number of inpatient files piling up in the pharmacy.

21.4.1.4 Policies and procedures are implemented to ensure that medications are dispensed on the written instructions of a designated health worker qualified and/or experienced in their use.

21.4.1.5 Policies and procedures are implemented to ensure that medications are dispensed in conjunction with other medications only after thorough checking for drug interactions by dispensing staff.

21.4.1.6 Medicines are securely and legibly labelled with relevant information as required by law or organisational policy.

Critical criterion

This is assessed in the pharmacy and in all areas in the organisation where medication is handled.

National laws and regulations must be applied, but must include at least the following:

- *Name of ward (if applicable)*
- *Name of patient and hospital number*
- *Generic/approved name or name of each active ingredient*
- *Direction with regard to manner in which medicine must be used*
- *Number of dose units in the container*
- *Date of dispensing*
- *Expiry date and batch number*
- *Additional labels with warnings and storage instructions according to local instructions.*

Linked criteria:
7.2.3.1
10.6.3.4 as well as related criteria in all in-patient services.
22.9.3.4
23.7.3.4
24.9.3.4

21.5 Control and Storage of Medication

21.5.1 Adequate facilities are available for the safe storage and dispensing of medications.

Standard Intent

Secure storage systems ensure that pharmaceuticals and related substances are held under conditions, which conform to statutory and the manufacturer's requirements.

Arrangements, including alarm systems, door access controls, and safes/vaults used to store controlled medicines exist to ensure the security of medicines.

The pharmacy or pharmaceutical service stores and dispenses medications in a clean and secure environment, which complies with laws, regulations and

professional practice standards. In particular, medications are clearly labelled, stored properly, and protected from heat, light and moisture.

Deep freeze, refrigeration, cold room and cool area facilities are provided for safe storage of certain medications. There is a mechanism to ensure that the temperature has been maintained throughout the life of the medications. Deep freezers and refrigerators are defrosted when necessary. Doors, hinges and seals are all functional.

Medications stored and dispensed from areas outside the pharmacy, for example patient care units, comply with the same safety measures.

There is a registry, log or other mechanism to monitor and account for controlled substances.

21.5.1 Criteria

21.5.1.1 Separate designated areas for the receipt and unpacking of incoming goods, are provided.

This criterion measures the availability of space for the 2 functions mentioned. The ideal situation should be the availability of a separate enclosure, but a "functional" separate area would be accepted.

This will be assessed only in the pharmacy.

Linked criteria:
1.2.2.3 for all criteria in this standard.
17.2.1.4 for all criteria in this standard.

21.5.1.2 Separate designated areas for the storage of normal stock of medicines are provided.

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

Critical criterion

With regard to flammables, the permissible amount stored in the pharmacy will be determined by National laws and regulations. The guiding principle here should be the requirements from the local Fire Department. This implies that the inspection by the Fire Department should include a visit to the pharmacy.

This will be assessed only in the pharmacies.
Linked criterion:
7.5.1.1

21.5.1.4 Separate designated storage areas, for materials under quarantine are provided, e.g. expired stock, damaged goods and compounded products awaiting testing and release.

These products are clearly marked and kept separately ensuring that these items are not mixed with other pharmaceutical supplies that are still in use. These products can

be stored on a shelf, as long it is a small volume and clearly marked in a carton box or other types of containers or a room.

This will be assessed only in the pharmacy, which is responsible for the storage of these items.

21.5.1.5 Secure storage facilities are available and include smoke detectors, security alarm systems and/or barriers.

The pharmacy must be lockable and exclude any unauthorised entry. The responsible pharmacist or another authorised person must keep the keys securely.
This refers to the pharmacy and pharmacy stores.

21.5.1.6 Stock control systems are managed in the pharmacy and other related departments.

Critical criterion

Stock control systems in the pharmacy and related departments can either be a manual or an electronic system or both. Some pharmacies have a dual system. Bulk stock in the store is controlled, but open stock is often not controlled unless an electronic dispensing system is in use. Under these conditions this criterion will be scored PC.

It is important to note that this criterion also refers to all departments where medication is stocked.

Linked criterion:
10.6.3.9as well as related criteria in all inpatient services
17.2.1.4
22.9.3.9
23.7.3.9
24.9.3.9

21.5.1.7 A management information system is available, which provides accurate statistics relating to pharmaceutical receipts and issues.

This criterion measures a number of aspects, e.g. statistics with regards to stock control; the monitoring of financial aspects; out-of-stock items; aged items; drug availability; etc.

This will be assessed only in the pharmacy.

Linked criterion:
6.1.1.1

21.5.1.8 Medicines are stored in a clean environment.

It is important to note that this criterion also refers to all departments where medication is stored.

In accordance with national laws and regulations, measures for control of pest infestations must be addressed.

Linked criteria:
10.6.3.5. and relevant criteria in all inpatient services.
22.9.3.5
23.7.3.5
24.9.3.5

21.5.1.9 The cold chain is maintained for medicines, where necessary.

Critical criterion

Protocols should be available addressing the cold chain all the way from the manufacturer to the end user. It is the responsibility of the pharmacist to ensure that the cold chain is maintained. It is also the responsibility of the pharmacist to ensure that medicines, which require to be kept cold, have not had the cold chain broken when received by the hospital .It is important to ensure that the cold chain is not broken during transport to the wards as well as in the wards.

A refrigerator equipped with a thermometer should be available to store products between 2 and 8°C. Temperatures need to be monitored and logged twice daily. The refrigerator should only be used for storage of pharmaceuticals. WHO approved dial thermometer, or alcohol thermometer, and not necessarily a min/max thermometer are required.

A freezer for the storage of polio and measles vaccines, where applicable, and ice packs must be available. Freezers/refrigerators must be connected to the emergency power supply.

Note that some medications are provided with colour coded blocks, which indicate if the cold chain has been broken.

It is important to note that this criterion also refers to all departments where medication is stored.

Linked criteria:
10.6.3.8as well as related criteria in all inpatient services
17.2.1.10
22.9.3.8
23.7.3.8
24.9.3.8

21.5.1.10 Medicine storage areas are protected from heat, light and moisture and temperatures are monitored and recorded.

The room temperature must be maintained below 25°C. Air conditioners must be installed. It is important that medication is not exposed to direct sunlight.

*This applies to **all areas** in the hospital where medication is stored.*
Linked criteria:
10.6.3.6 and 7as well as related criteria in all in-patient services
22.9.3.6
23.7.3.6
24.9.3.6

21.5.1.11 Medicines identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised staff have a key.

National laws and regulations will determine the nature of these medications.
Scheduled (controlled) medicines/narcotics/barbiturates and other dangerous medicines needs to be stored under lock and key at all times, but national requirements will apply.

The "substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets but solid wooden cupboards are also acceptable.

*This applies to **all areas** in the hospital where medication is stored.*

Linked criteria:
10.6.3.2 and related criteria in all in-patient services.
22.9.3.2
23.7.3.2
24.9.3.2

21.5.1.12 Medicines identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion

Compliance is measured against the local medication control regulations.
*This applies to **all areas** in the hospital where medication is stored.*

Linked criteria:
10.6.3.3as well as related criteria in all in-patient services
22.9.3.3
23.7.3.3
24.9.3.3

21.6. Quality Improvement

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

Standard Intent

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

It is the responsibility of 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 for quality monitoring and improvement.

a) completion of prescriptions

b) the use of antibiotics and other medications
c) medication errors
d) adverse medication effects
e) patient and family expectations and satisfaction
f) audits of medication storage/use in the departments
g) monitoring of financial aspects
h) out of stock items, aged items
i) analysis of complaints, negative incidents, patient satisfaction.

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
- 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
- as well as graphed results, where appropriate.

A once-off project, for example, supplying a thermometer for a refrigerator, will be scored as NC.

21.6.1 Criteria

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

Once the pharmaceutical service has analysed its mission, defined its objectives, and identified all its stakeholders, there needs to be a way in which progress towards achieving these objectives can be measured.

The minimum requirement for considering compliance will be the availability of evidence of:

- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criteria:
8.2.2.1
10.6.2.5 and 6 as well as all related criteria in all clinical services
21.9.1.2

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

Measurable indicators must reflect processes related to the pharmaceutical service. Processes for quality improvement are selected in order of priority for evaluation and improvement in the quality of the service provided

This should include at least medication errors and adverse effects.

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

Regular measurements should be done to check on the performance indicators as above and these results will allow for on-going monitoring of either poor performance against the standards, or improvements over time. Ongoing monitoring is required in order to demonstrate that improvements are being sustained.

21.6.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.
Where the documentation (patient record) audit is a hospital-wide multidisciplinary process that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

These audit processes can include auditing of in and/outpatient prescriptions, order forms, the audit trails that take place with the use of electronic systems, etc.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

21.6.1.5 Clinical audits are undertaken to monitor the quality of care provided.

21.7 Patient Rights

21.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

21.7.1 Criteria

21.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable.

Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

21.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

21.7.1.3 The personnel respect the rights of patients and families to accept treatment and to refuse treatment.

Linked criterion:
5.4.1.1

21.8 Prevention and Control of Infection

21.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

21.8.1 Criteria

21.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

The department participates in and has documented evidence of, the identification of risks in the department. Such documentation must forms part of the organisation-wide infection control processes.

Examples of such risks include hand-washing practices, cleaning and disinfection of equipment, wearing of protective clothing, exposure to aerosols and droplets.

Linked criterion:
9.2.1.1

21.8.1.2 Infection control processes includes prevention of infection while undertaking sterile procedures.

21.8.1.3 Infection control processes includes prevention of infection during the process of preparation and dispensing of medication.

21.8.1.4 Infection control processes includes prevention of water contamination during the preparation of suspensions/liquid medications.

21.9 Risk Management

21.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

21.9.1 Criteria

21.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor related risks, financial, and legal risks, physical facility, security and environmental risks. should be included.

Linked criterion:
7.1.1.1

21.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
10.6.2.4 - 6 as well as all related criteria in all clinical services.
21.6.1.1

21.9.1.3 Security measures are in place and implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criteria:
7.4.1.4, 7.5.1.1

21.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

21.9.1.5 Organisation's policy on handling, segregation, storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, segregation, collecting, storing and disposing of healthcare waste.

Linked criterion:
7.7.1.1

SE 22 EMERGENCY CARE

OVERVIEW OF EMERGENCY CARE STANDARDS

Trauma and emergency services are best delivered when institutions form part of a trauma/emergency system rather than operating as independent, uncoordinated elements. In order to plan a system the capabilities of individual organisations need to be catalogued; this information is then used to guide service delivery for medical transport systems and to make system-wide disaster plans. 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.

Emergency care is provided at many different levels, from primary health facilities, to referral hospitals and, clearly, the expectations in terms of expertise and equipment are different. Most emergency units form part of a larger organisation, usually a hospital, which is responsible for certain management and administrative functions such as human resource and provisioning management.

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.

Standards

22.1 Coordination of Patient Care

22.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

22.1.1 Criteria

22.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" caregivers, i.e. medical practitioners and nurses.

Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists. It is important to assess the availability of medical practitioners, especially after-hours cover, including week-ends and public holidays.

Linked criteria
1.2.7.2
2.2.1.1
2.5.1.1

23.1.1.1 The individuals responsible for the patient's care are qualified and registered with the relevant regulatory or professional body.

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The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels .

Personnel assisting in the provision of emergency services are appropriately qualified, trained and supervised and are available in sufficient numbers for the emergency services provided.

The level of qualifications required would be dependent on the category of the relevant hospital.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
22.6.2.2, 22.9.1.1, 22.9.2.1

22.1.1.2 The individuals responsible for the patient's care are identified and made known to the patient and other personnel.

*Name badges should be worn by all staff members at all times.**Patient interviews** will reveal whether staff members introduce themselves to patients.*

Linked criterion:
22.8.1.3

22.1.1.3 During the hours of operation there are an adequate number of qualified professionals available to provide continuous cover to all sections at all times.

Root criterion for 22.11.4 to 6
Linked criterion:
2.2.1.5

22.1.1.4 All emergency services personnel maintain skills in advanced life support in accordance with organisational policy.

Critical criterion
Linked criterion:
30.3.1.4

22.1.1.5 Medical cover is reflected on a roster and each practitioner on the roster is contactable by telephone or pager, or other two-way communication method.

Critical criterion
Linked criterion:
22.1.1.4

22.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and coordinate care for their patients (for example, team delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be less complicated when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

22.1.2 Criteria

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

Root criterion

This refers to the relevant forms/documents that need to be present in the patient file, 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:
1.3.2.4

22.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (medical practitioners, nurses, professions allied to medicine, social workers, etc) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record. Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

Compliance will be verified during the ***patient record audit.***
If the notes of medical practitioners and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criteria:
22.6.2.1

22.1.2.3 Information exchanged includes a summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

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

If the notes of medical practitioners and other health care professionals are not available because they are kept separately in another location, this criterion will be scored PC.

22.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.
Compliance will be verified during the ***patient record audit.***

22.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.

Methods of verifying signatures and designations could include:
- *names and designations printed below signatures*
- *stamps indicating names and designations and/or*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

22.1.2.6 The date of each patient record entry can be identified.

Records must follow a chronological order to allow for a logical flow of information.
Compliance will be verified during the ***patient record audit.***

22.1.2.7 The time of each patient record entry can be identified.

Patient records include time of arrival at the facility and each time that the patient is assessed by a health care professional.

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

22.2 Facilities And Equipment

22.2.1 Adequate resources are available for the provision of safe care to patients in the unit.

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice

rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate ablution facilities for the number of patients in the unit, as determined by national legislation.

There is adequate lighting and ventilation.

Nurse call systems are available at bedsides and in bathrooms and toilets and are connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily. Each room is provided with a socket outlet that is connected to the emergency power supply.

22.2.1 Criteria

22.2.1.1 Patient and staff accommodation in the service is adequate to meet patient care needs.

Root criterion.

There should be adequate office space for personnel; clean hygienic sluice rooms, treatment and dressing rooms; adequate, tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients, as well as the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6

22.2.1.2 Facilities allow privacy when providing personal information, or undergoing examination or procedures.

Linked criterion:
22.13.1.2

22.2.1.3 Electricity and water is available in accordance with the policies of the organisation.

Unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

22.2.1.4 There is a waiting area for patients and families.

22.2.1.5 There is adequate seating in the waiting area.

22.2.1.6 Wheelchair accessible toilets are available.

Linked criterion:
4.2.1.4

22.2.1.7 Quiet and private areas are available for waiting relatives and grieving or otherwise distressed relatives or carers.

22.2.1.8 There is access to a functioning telephone facility for use by the public.

22.2.2 Clinical areas within the emergency unit are adequate to meet the needs of patients.

Standard Intent

In situations of limited resources, most emergency units will not be located in a modern purpose built facility. However, the clinical areas may be arranged in a way that assists management of the most critical patients. There should be a designated resuscitation area. The arrival of critical patients may be unpredictable, particularly in regions where patients use unofficial emergency transport, and there should be an alarm system, audible in the staff rest areas to indicate the arrival of a critical patient. Major and regional units should be equipped with a decontamination area for the management of patients exposed to hazardous materials. This decontamination shower should be in close proximity to the ambulance entrance, should provide for patient privacy, should have a raised barrier to protect staff, should be spacious enough for patient and staff and should have good water run off such that contaminated material can be collected and isolated. Operating theatre facilities may be located on a different floor in which case there must be a "lift over ride" mechanism. Comprehensive trauma and emergency care will require in patient care for most major cases.

22.2.2 Criteria

22.2.2.1 There is a designated triage area.

22.2.2.2 There is a designated resuscitation area.

22.2.2.3 There is a mechanism for the summoning of medical help in an emergency.

Critical criterion

This refers to the summoning of medical help both from within the unit itself, from other departments within the facility or from outside the hospital.

Various methods such as an alarm, intercom, alert button, besides functional telephone/pager systems are acceptable.

Linked criterion:
1.2.2.3

22.2.2.4 Oxygen and vacuum supplies meet patient care needs.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and suction units in working order to meet the patients' needs. There must also be enough functional flow-meters.

Any evidence of infection control deficiencies, e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9 (Prevention and Control of Infections).

Linked criterion:
29.2.2.1

22.2.2.5 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

Linked criteria:
22.2.3.1, 22.6.2.1

22.2.2.6 There is adequate storage space to enable rapid retrieval and removal of equipment when needed.

This applies to medical equipment, which should be kept in a purpose built store. The store should be spacious for ease access

22.2.2.7 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture..

Linked criterion:
31.2.1.5

22.2.2.8 Each patient has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess whether responses are effective by interviewing patients/parents/gurdian and reviewing customer's complaints.

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criterion:
29.2.1.2

22.2.2.9 There is a low pressure, handheld shower suitable for the management of patients contaminated with hazardous materials.

22.2.2.10 There is access to inpatient facilities consistent with the level of emergency care.

Linked criterion:
4.1.1.10

22.2.2.11 There is easy access to the operating theatre.

22.2.3 Resuscitation equipment is available in accordance with the policies of the organisation.

Standard Intent

Resuscitation equipment must be available in the unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or *automated external defibrillator* (AED) within 3 minutes of any patient collapsing.

It is important to carry a range of adult and paediatric size equipment and a reasonable selection within each range. National requirements will apply.

Resuscitation equipment includes at least:

- a defibrillator with adult paddles / pads (and infant paddles / pads where applicable)
- an ECG monitor
- a CPR board (if required)
- suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- a bag-mask manual ventilator
- a range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable
- an introducer /stylet for endotracheal intubation
- a syringe to inflate the ETT cuff
- oro-pharyngeal tubes
- equipment to perform an emergency crico-thyroidotomy – (needle and surgical)
- appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
- plasma expanders
- pulse oximeter.

22.2.3 Criteria

22.2.3.1 Resuscitation equipment is available in accordance with the policies of the organisation.

Critical criterion

Must include at least the items mentioned in the intent statement and according to national requirements.

Resuscitation equipment must be available in the unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry

dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

Linked criterion:
30.2.1.2

22.2.3.2 Recommended appliances are available for specialised resuscitations.

Trauma units should have a safe mechanism for warming patients, hot air warmers are recommended but where these are not available, protocols guide the safe use of alternative devices.
There should be devices for:
- the stabilisation of the spine in adults and children.
- the stabilisation of long bone fractures.
- limb traction.
- pelvic compression.
- preventing hypothermia and for the active warming of patients.
Staff is trained in the use of specialised resuscitation equipment/devices.

Stabilisation of the spine is an essential initial step in the management of the poly-trauma patient. A range of sizes of hard cervical collars, stabilising head blocks plus padded spinal boards must be available. Where possible, these should duplicate those used by the Emergency Medical Services (EMS) so that they can be exchanged without compromising the patient whose spine has been properly stabilised by pre hospital care providers.

Pelvic compression can be a life saving procedure and there should be a mechanism for this in all trauma units. Pelvic clamps are available, but pelvic wrapping can also be effective in less sophisticated environments.

22.2.3.3 Diagnostic and vital signs monitoring equipment is available as per organisational policy.

Basic vital signs measurement: ECG (where applicable), Dynamaps, peak flow meters etc.

Diagnostic "point of care" or "bedside" tests are performed within the emergency unit by non laboratory staff and give rapid results. They are particularly important where laboratory facilities are not available on the premises; transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the emergency unit. Personnel are trained in the use of diagnostic equipment and quality controls are in place for all diagnostic equipment.
The following are required as the minimum. Equipment for:

- *determination of blood glucose levels*
- *finger-prick haemoglobin or haematocrit testing*
- *urine testing*
- *Falciparum malaria testing (in areas where malaria is endemic, or where tourists are frequently seen) and*
- *blood gas analysis within 5 minutes (this should include lactate measurements if required by organisation policy).*

22.2.4 There is a rest area for personnel in close proximity to the clinical areas.

Standard Intent

Rest areas for personnel are adequately equipped to allow personnel to remain in the vicinity of the unit at all times. The type of facilities provided will vary between units and will depend on the length of shifts undertaken and access to other refreshment facilities.

22.2.4 Criteria

22.2.4.1 There is an adequately equipped kitchen, with at least a kettle, toaster and microwave.

If there is no kitchen in the staff rest area, but in close proximity to the department it is considered compliant. The same applies to criteria 2 and 3 in this standard.

22.2.4.2 There are rest room facilities for personnel including a changing area, toilet and hand-washing facilities.

22.2.4.3 Where personnel undertake 24 hour shifts, there are sleeping and shower facilities.

22.2.4.4 The rest area is equipped with a telephone or intercom system.

22.3 Visitors Control

22.3.1 A system of visitors control is maintained to ensure the safety of patients and personnel.

Standard Intent

Controlling visitors' access to the unit is important, not only as a security precaution, but because anxious relatives in clinical areas can impede delivery of services. Additionally, community emergencies, VIP admissions and other newsworthy events may lead to invasion by the media. Policies should be available to guide all personnel, but clerical and security personnel are particularly important in implementing visitor's control.

22.3.1 Criteria

22.3.1.1 The organisation's policy on visitors to the emergency unit is implemented

Root criterion
Linked criterion:
22.15.1.3

22.3.1.2 There is a system to inform patients and family of the visitors' policy.

22.3.1.3 Areas, where access is denied to persons other than staff members, are clearly marked.

22.3.1.4 The discretionary powers of the personnel in charge of the service relating to visitors under special circumstances are documented.

22.3.1.5 Policies regarding media invasion are implemented to guide clinical and security personnel.

22.4 Patient Registers

22.4.1 Patient registers are kept and comply with national requirements and/or organisational policy.

Standard Intent

Organisations may be required by law and regulation to maintain registers of patients attending the emergency unit and patients receiving radiological investigations. Attendance registers should include mode of arrival, time of arrival, name, date, treatment administered and information on final disposition (admission, discharge, death or transfer).

22.4.1 Criteria

22.4.1.1 A register is kept of patients attending the emergency unit.

Root criterion

22.4.1.2 The register contains at least the patient's name, patient specific identification number, age, gender, date and time of admission, treatment, procedures, discharge, referral or death.

Critical criterion
Linked criterion:
4.2.2.1

22.4.1.3 The information in the register is used to monitor waiting periods from time of arrival to time of assessment.

Linked criterion:
22.12.1.2

22.5 Clinical Practice Guidelines

22.5.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, and standards of practice and/or care pathways. Regardless

of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits.

This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

22.5.1 Criteria

22.5.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

Guidelines/protocols "relevant to the patients and services" are assessed in each department according to the disease profiles of the patients admitted.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC. In the absence of guidelines, this criterion will be scored NC.

Linked criteria:
1.3.2.1

22.5.1.2 Clinical practice guidelines include protocols for time critical states.

Time critical states are considered to be those where initial treatment takes place concurrently with assessment and where time spent telephoning for advice will almost certainly affect patient outcome negatively. It is difficult to provide a complete list and there is a large "grey area". Specialised emergency centres, e.g. trauma units or paediatric emergency centres may be exempted from some elements of this list. For general emergency centres, clinical guidelines for the management of time critical states should include at least the following:

1. *Chest pain (including acute MI)*
2. *Acute stroke*
3. *Airway obstruction*
4. *Respiratory arrest and respiratory failure*
5. *Head injury with GCS<12*
6. *Evaluation and resuscitation of the poly-trauma patient*
7. *Suspected ruptured major aneurysm*
8. *Control of major haemorrhage*
9. *Cardiac arrest*
10. *Arrhythmias resulting in hypotension*
11. *Status epilepticus*
12. *Anaphylactic shock*
13. *hypoglycemia*
14. *the unconscious patient*

22.5.1.3 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem prone conditions is considered for auditing. If guidelines are available but structured clinical audits are not done, this criterion is scored NC. Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criteria:
8.2.1.4
22.8.1.4

22.5.1.4 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

22.6 Assessment of Patients

22.6.1 The organisation has a formal triage process, which uses written guidelines to determine urgency

Standard Intent

This standard refers to initial triage by either a medical practitioner or registered nurse. In urgent cases, initial management will take place simultaneously with assessment. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

It is essential that triage assessments be properly documented and legible and that they can be easily retrieved from the patient's record. The triage assessment should take place within time frames established by the professional societies or the health organisation for the identification of patients with immediate needs e.g.

Red Patients:	Immediate
Orange Patients:	Less than 20 minutes
Yellow Patients:	Less than 60 minutes
Green Patients:	Less than 240 minutes

22.6.1 Criteria

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

22.6.1.1 Clinical records of emergency patients include the time of arrival.

22.6.1.2 The triage category for each patient is recorded.

Linked criterion:
22.6.2.1

22.6.1.3 Clinical records of emergency patients include time of referral to medical practitioner.

22.6.1.4 Waiting times from triage categorisation to initial assessment are monitored.

Critical criterion
Linked criterion:
22.12.1.2

22.6.2 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters the Emergency Unit, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided. Assessments must be completed with due regard to privacy, this is particularly important when the patient is a victim of social or sexual violence.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations.

The health organisation determines the time frame for completing assessments. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status is important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process is modified in accordance with local custom. The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs so that care and treatment can begin. When the medical assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

22.6.2 Criteria

22.6.2.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care.

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed

assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy.

Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

Time frames for the assessment of patients need to be established for each discipline, e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

Linked criteria:
1.2.6.1
22.1.2.2
22.6.1.2

22.6.2.2 Only those individuals permitted by applicable laws and regulations or by registration and appropriate training/experience perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of notes made in the patient record by the medical practitioner or relevant clinical personnel other than nurses will affect the outcome of the audit process.*

Linked criteria:
22.1.1.2, 22.1.2.5

22.6.2.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline.
These forms should include at least:

- *history*
- *physical examination*
- *vital signs*
- *provisional diagnosis*
- *diagnostic procedures*
- *treatment planning*

The absence of medical notes relevant clinical personnel, in the patient record will affect the outcome of the audit process.

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

22.6.2.4 Assessment findings are documented in the patient's clinical record and are readily available to those responsible for the patient's care.

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

Linked criteria:
22.1.2.2

22.7 Diagnostic Services

22.7.1 Diagnostic imaging services are available to meet patient needs.

Standard Intent

The organisation leaders ensure that appropriate diagnostic imaging facilities are available, that there are radiation safety programmes in place, and that individuals with adequate training, skills, orientation and experience are available to undertake X-ray procedures and interpret the results.

The diagnostic imaging service allows for immediate decision-making by practitioners through the provision of emergency services and the provision of emergency reports as necessary.

22.7.1 Criteria

22.7.1.1 Adequate and convenient diagnostic imaging services are available at all times.

It is important to note that this criterion addresses a number of issues.

With "adequate" one should take into consideration the level of service that is required e.g. does the tertiary hospital provide a CAT scan, is there a Radiologist.

The service should meet the needs of the population that it serves e.g. if the service is only available 2 or 3 days per week, but the need is there for a daily service, then this would warrant a PC score.

If equipment is broken or supplies are lacking, or staff are inadequate and the full scope of service (as required) cannot be rendered then the criterion should be scored down.

"Convenient" refers to the patient's experience and it should be considered that sometimes patients are referred "unnecessarily" somewhere else because of personnel shortage, broken equipment, lack of supplies, etc. Or they have to be admitted on Saturday to wait for X-rays on the Monday, in which case this criterion will be scored down.

This would include the after-hour service. If there is no service available when required, this criterion will be scored PC.

Where SE 20 forms part of the assessment at the facility, the identified linked criteria will apply.

This criterion should be scored similarly to criterion 20.1.1.1 in SE 20 Diagnostic Radiology and Imaging services.

Linked criteria:
1.2.2.3, 1.2.7.2

22.7.1.2 Established waiting times for diagnostic imaging studies to be done, according to triage status, are monitored.

Linked criteria:
22.12.1.2

22.7.1.3 Established waiting times for diagnostic images to be available are monitored.

Linked criteria:
22.12.1.2

22.7.1.4 Where X-rays are initially read by emergency unit medical personnel, there is a clearly defined system for review by appropriately qualified diagnostic imaging personnel, when required.

Linked criteria:
20.1.3.4

22.7.2 The emergency unit is adequately supported by clinical laboratory services.

Standard Intent

Laboratory services, including those required for emergencies and after-hours, may be provided within the organisation, by agreement with another organisation, or both if outside sources are convenient for the patient to access. Whatever the arrangement, it is expected that laboratory services will be available 24/7 and should be on site or in close proximity to the emergency unit.

Point of care" or "bedside" tests are performed within the outpatient/emergency department by non-laboratory personnel and give rapid results. They are particularly important where laboratory facilities are not available on the premises; transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the emergency unit. Determination of blood glucose, either finger-prick haemoglobin or haematocrit testing; and urine testing are considered essential for an outpatient/emergency department. Centres in areas where malaria is endemic, or where tourists are frequently seen, should also have rapid, antigen based tests for the diagnosis of Falciparum malaria. Training and quality control are required for all point of care tests.

The majority of urgent clinical decisions can be made based on the results of point of care testing outlined above; however, emergency units require urgent laboratory services for the provision of specialised testing.

22.7.2 Criteria

22.7.2.1 Laboratory services are available at all times.

Critical criterion

Where SE 19 forms part of the assessment at the facility the identified linked criteria will apply.

This criterion should be scored similarly to criterion 19.1.1.1 in SE 19 Laboratory service.

Linked criteria:
1.2.3.3, 1.2.7.2

22.7.2.2 Established waiting times for laboratory tests to be done, according to triage status, are monitored.

Linked criterion
22.12.1.2

22.7.2.3 Established waiting times for laboratory results to be available are monitored.

Linked criterion
19.2.3.1
22.12.1.2

22.8 Patient Care

22.8.1 Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Standard Intent

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent eg., consent may be given verbally, by signing a consent form, or through some other mechanism. Patients and families understand who may give consent in addition to the patient.

Designated individuals are identified (according to national arrangements or organisational policy) to inform patients and to obtain and document patient consent, e.g. a doctor for a surgical procedure or a nurse for HIV testing. These personnel clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications
- consideration of the surgical and non-surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written informed consent. Leaders document the processes for obtaining informed consent.

The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledges full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

22.8.1 Criteria

22.8.1.1 There is a documented process for obtaining informed consent.

Root criterion

This section refers to all instances where patients give informed consent and compliance will be verified during the patient ***record audit****.*

If consent was not required for the patient records audited, this whole standard becomes NA.

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 22.8.1.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC, because the process has not been implemented.

Linked criteria:
5.6.1.1
22.13.1.1

22.8.1.2 Patients are informed about their condition, and the proposed treatment.

22.8.1.3 Patients know the identity of the medical practitioner or other professional practitioner responsible for their care.

This will be assessed during ***patient interviews.***

Linked criterion:
22.1.1.3

22.8.1.4 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion

*Compliance will be verified during the **patient record audit.***
If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information indicated in the relevant criteria above. This criterion and the relevant criteria above will be scored C.

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria above will receive the same score.

Linked criteria:
22.8.1.1

22.8.2 Invasive procedures and minor operations performed in the emergency unit are controlled by policy.

Standard Intent

Patients attending the emergency unit may require invasive procedures such as central venous cannulation or tube thoracostomy.

Policies are required to define who should be doing these procedures, to ensure that they are performed based on clinical need and to control sterility of the procedure. Persons performing invasive procedures are appropriately trained.

Adverse events resulting from invasive procedures should be documented.

22.8.2 Criteria

22.8.2.1 Protocols guide medication use for sedation, pain and anaesthesia.

Linked criterion:
22.9.1.1

22.8.2.2 Protocols address appropriate monitoring during and after the procedure.

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

22.8.2.3 The procedure and the name of the person performing the procedure are recorded in the patient's record.

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

22.8.2.4 Unsuccessful or complicated procedures are recorded.

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

22.8.3 Patients being transferred from the emergency unit to the operating room are appropriately prepared.

Standard Intent

For a successful surgical outcome, patients being transferred to the operating room may require prior optimisation of their medical condition. This need is assessed in the context of their current illness or injury: in the case of active bleeding, for example, surgery may be the intervention required to normalise the physiological state and pre operative resuscitation may be fruitless. In cases of lower surgical acuity, particularly in patients with co-morbid pathologies, proper assessment and preparation will improve outcome.

In addition to optimisation of the patient's physical condition, pre operative preparation also includes washing and interventions such as catheterisation and intravenous cannulation. Policies should address responsibility for this.

Results of diagnostic tests must be available to the surgical and anaesthetic teams in the operating room.

Patients requiring emergency surgery are at risk of decompensation if they are left unattended in an operating department holding area and an appropriately qualified person, the level of qualification depending on the patient's needs, should accompany them. This person is also responsible for a handover to the operating department team.

An important aspect of pre operative preparation is the consent process.

22.8.3 Criteria

22.8.3.1 The indication for surgery is recorded before anaesthesia.

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

22.8.2.2 Policies that address nursing preparation of patients being transferred to the operating theatre are implemented.

22.8.2.3 Patients being transferred to the operating room are accompanied by an appropriately qualified person, as determined by organisation policy.

22.8.4 Post operative assessments are documented.

Standard Intent

A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report is available within a time frame needed to provide post-surgical care to the patient.

Post-operative monitoring is appropriate to the patient's condition and the procedure performed.

Results of monitoring influence intra- and post-operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

22.8.4 Criteria

Compliance with the following criteria will be verified during the ***patient record audit.***

22.8.4.1 A post operative diagnosis is documented.

22.8.4.2 The name of the medical practitioner and the names of other personnel as required by law are documented.

22.8.4.3 The patient's physiological status is monitored during the immediate post-surgery period.

Critical criterion

Linked criterion:
22.6.2.1

22.8.5 The organisation implements processes to support the patient in managing pain.

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and re-assessment
- communicate with, and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs
- educate health service providersin pain assessment and management.

22.8.5 Criteria

22.8.5.1 The assessment process makes provision for patients in pain to be identified.

22.8.5.2 Patients in pain receive care according to pain management guidelines.

Critical criterion

There should be evidence that all clinical professionals dealing with the patient's pain management have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment.

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

Linked criteria:
1.3.2.1
22.5.1.3

22.8.5.3 Patients and families are educated about pain and pain management.

*Compliance will be verified during the **patient record audit and patient interviews.***

22.8.5.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.2

22.8.6 There is access to emergency blood and blood products in accordance with organisational policy.

Standard Intent

Hospitals are required to have a blood bank on the premises. Other facilities should have emergency blood on site with access to banked blood within 1 hour. Referral and district hospitals should have at least 4 units of on-site blood, 2 units are considered minimum requirement for primary centres.

The type and amount of emergency blood and blood products to be kept on site will be determined by organisational policy.

22.8.6.1 Emergency blood is available at all times.

The criterion does not state that emergency blood must be on site, but it must be available within an acceptable time frame.

Where emergency blood is not kept on site, criteria 22.8.6.2 to 4 will be NA.

22.8.6.2 There is a designated refrigerator for emergency blood and blood products.

22.8.6.3 The temperature of the refrigerator is recorded and monitored daily.

22.8.6.4 Emergency blood is subject to stock control, which includes the replacement of stock before its expiry date.

Critical criterion
Linked criterion:
1.2.2.2

22.9 Medication

22.9.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, and regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in organisational policy.

22.9.1 Criteria

22.9.1.1 Policies and procedures that guide the safe prescribing, ordering, storage, dispensing and administration of medications are implemented.

Root criterion for all criteria in standards 22.9.1, 22.9.2 and 22.9.3

These policies need to be developed by all the role players i.e. medical practitioners, nurses and pharmacists.

National regulations will apply.
Compliance will be verified during the ***patient record audit.***

Linked criteria:
1.2.6.1
21.3.1.1
22.1.1.2

22.9.1.2 Policies and procedures that guide dispensing of medications in the unit are implemented.

Linked criterion:
21.4.1.2

22.9.1.3 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
21.3.1.1

22.9.2.3

22.9.1.4 Only those permitted by the organisation and by relevant laws and regulations prescribe medication.

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

Linked criteria:
21.2.1.1 to 21.2.1.5
22.1.1.2

22.9.1.5 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the patient's medical practitioner and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over-the counter and homeopathic medicines.

These should be re-prescribed on the prescription sheet if indicated.

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

22.9.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, medical practitioner, nurse, and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed, and to evaluate the patient for adverse effects.

The organisation follows national requirements for the reporting of adverse effects. Medical practitioners, nurses, and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such personnel training.

22.9.2 Criteria

22.9.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:
22.1.1.2

22.9.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

22.9.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
21.3.1.1
22.9.1.3

22.9.2.4 Health professionals monitor medication effects on patients collaboratively.

***Patient record audits** should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the medical practitioner.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional information may be required le.g., plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

22.9.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

*An **adverse drug reaction** (**ADR**) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.*

*Compliance is verified during the **patient record audit.***
Documentation showing that the reaction was reported to the medical practitioner and the pharmacist will be sought.

Linked criteria:
7.1.1.7
21.6.1.1
22.15.1.2

22.9.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
21.6.1.1
22.15.1.2

22.9.2.7 The medications prescribed for and administered to each patient are recorded.

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

22.9.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

22.9.3 Criteria

22.9.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerators, etc) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant personnel only.

An unlocked refrigerator in an unlocked room will be scored NC.

Linked criterion:
21.5.1.10

22.9.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

national laws and regulations or organisational policy will determine the nature of these medications.

22.9.3.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion

Compliance needs to be measured against the local medicine control regulations. Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

22.9.3.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion

national regulations apply, but must include at least the following:

- *name of unit and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regards to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number and*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

22.9.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

Linked criterion:
21.5.1.7

22.9.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

22.9.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication.

Linked criterion:
21.5.1.9

22.9.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion
Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

22.9.3.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

22.10 Patient and Family Education

22.10.1 Education supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Personnel collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to participate and make decisions on how to continue with care continue care at home.
.
Variables like educational literacy, beliefs and limitations are taken into account.
Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record. Education is provided to

support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, e.g. changing dressings, feeding and medication administration, they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance, instruction in the safe and effective use of medications and medical equipment.

Community organisations that support health promotion and disease prevention education are identified and, when possible, ongoing relationships are established.

*Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.*

22.10.1 Criteria

22.10.1.1 Patients and families indicate that they have been informed about their diagnosis.

22.10.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
22.13.1.1

22.10.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use.

22.10.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

22.11 Continuity of Care

22.11.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and Coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providersmay be involved in providing care. Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may

occur, exposing the patient to avoidable risks.

22.11.1 Criteria

22.11.1.1 Established criteria or policies that determine the appropriateness of transfers within the organisation are implemented.

Root criterion

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

22.11.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

22.11.1.3 Continuity and coordination are evident throughout all phases of patient care.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

22.11.1.4 The record of the patient accompanies the patient when transferred within the organisation.

22.11.2 The organisation implements policies for the management of patients requiring short term observation and care.

Standard Intent

Where emergency units have short stay facilities, also known as admission/overnight or observation facilities, they should be controlled by policies, which address:

- which cases may appropriately be observed in the emergency unit rather than in in-patient facilities
- who is responsible for the patient
- timing of medical reassessment
- length of stay.

The facilities should be adequate for safe medical care, and medical records should clearly state the parameters under observation and actions to be taken should these parameters change.

22.11.2 Criteria

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

Root criterion
Linked criterion:
4.2.2.5
22.6.2.1

22.11.2.2 The organisation has established appropriate time frames, which limit holding time in the emergency unit.

22.11.2.3 Patients under observation are re-assessed at appropriate intervals, to determine their response to care and treatment, and this is documented in the record.

Critical criterion

Compliance for this criterion and the following two criteria will be verified during the ***patient record audit.***

Linked criterion:
22.11.2.1

22.11.2.4 Any significant changes in the patient's condition are noted in the patient's record and acted upon appropriately.

22.11.2.5 Any patient care meetings or other discussions are noted in the patient's record.

22.11.2.6 Holding times are monitored and audited.

Linked criterion:
22.12.1.2

22.11.3 There is a process for admitting patients to in-patient facilities.

Standard Intent

The time that patients spend waiting for transfer to in-patient facilities should be minimised. Not only is this in the interest of patients' comfort and definitive management, but long holding times have a significant impact on the functioning of the emergency unit, using space, resources and nursing time. Admission delays are often the result of system failures and processes should be designed to deal with this. The emergency unit can become congested when there is a lack of in patient beds. Certain strategies may be implemented to manage in patient beds more efficiently, such as more frequent consultant ward rounds, and "escalation policy" to address periods of particular overcrowding can be developed in advance with in-patient personnel.

22.11.3 Criteria

22.11.3.1 There is a process, known to personnel, for admitting patients to the organisation.

Root criterion *Linked criterion:* *4.2.2.2*

22.11.3.2 The unit which accepts the patient for admission is noted in the patient record.

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

22.11.3.3 The time of transfer is recorded.

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

22.11.3.4 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.

Linked criterion: *4.2.2.6*

22.11.4 There is a process known to personnel to appropriately refer patients for specialised consultation/ investigations at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations that may not be available locally, or to have patients receive specialized treatment that the referring organisation may be unable to provide. The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then returned to the original facility.

22.11.4 Criteria

22.11.4.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

Root criterion *The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.* *Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.*

*Compliance for this criterion and the following will be verified during the **patient record audit.***

Linked criterion:
1.2.5.4

22.11.4.2 A copy of the referral note is available in the patient record.

22.11.4.3 Follow up care based on the findings of investigations/consultations performed outside the organisation is noted in the patient record.

22.11.5 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation/investigations at another health facility for treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

While emergency units are obliged to resuscitate and stabilise all who need it, the patient may require transfer to another facility, either to address their on-going needs more appropriately, or because of patient or family choice or financial concerns

In a well organised system, the capabilities of individual organisations will be catalogued and co-ordinated, so that arrangements exists with units to which the facility frequently refers. When transfer criteria and processes are formally agreed in advance, patients are more likely to receive appropriate emergency care when their needs exceed the capabilities of the facility.

To ensure continuity of care, adequate information must accompany the patient. Appropriate information should accompany the patient, including at least:

- the reason for transfer
- any special conditions related to transfer
- the condition of the patient before transfer any interventions provided by the referring organisation.

22.11.5 Criteria

22.11.5.1 There is a documented process for transferring patients to other organisations for specialised and support services.

Root criterion
Linked criteria:
1.2.5.4
4.1.1.10
22.11.5.7

22.11.5.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

22.11.5.3 The process for transferring the patient considers transportation needs.

22.11.5.4 A policy that dictates that the responsible clinician communicates the level of required care to Emergency Medical (ambulance) services is implemented.

22.11.5.5 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

Linked criterion where the organisation operates its own ambulance service.
3.4.2.4

22.11.5.6 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

22.11.5.7 A copy of the transfer summary is available in the patient record.

Critical criterion

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criteria:
22.11.5.1

22.11.5.8 The health organisation agreeing to receive the patient is noted in the patient's record.

22.11.6 There is an organised process to appropriately discharge patients who are being treated and released.

Standard Intent

The organisation begins to plan for the patients' continuing needs as early as possible in the care process. Instructions for discharge and follow up visits must be clear and provided in writing. The discharge note is one of the most important documents to ensure continuity of care and facilitate correct management at

subsequent visits. Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.
The note contains at least the following information:

a) The diagnosis of main and significant illnesses
b) Management of the presenting problem
c) Discharge medications
d) Follow-up arrangements.

22.11.6 Criteria

22.11.6.1 There is a documented process to appropriately discharge patients.

Root criterion
Linked criterion:
1.2.5.4

22.11.6.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

Compliance for this criterion and the following will be verified through ***patient record audits****.*

22.11.6.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow-up instructions may be provided to the patient by the medical practitioner or by the nurse, following instructions from the medical practitioner.

The instructions should include medications, wound care, possible complications, return for follow up care, when and where to obtain urgent care, etc.

22.11.6.4 A discharge note, which includes at least items a) to d) in the intent statement above, is written, by the medical practitioner when each patient is discharged.

22.11.6.5 Each record contains a copy of the discharge note.

22.12 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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/co-ordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) patient assessment
b) resuscitation interventions
c) surgical procedures carried out
d) the use of antibiotics and other medications and medication errors
e) the use of anaesthesia
f) the use of blood and blood products
g) waiting times
h) patient and family expectations and satisfaction.

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.

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

Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, e.g., monitoring the checking of emergency trolley over time, will be scored PC.

22.12.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit; participation in documentation (patient record) audit and*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

22.12.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits. These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings

or specialised investigative studies. An indicator, in this context, is a measure used to determine improvements in clinical care over time.

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

Linked criteria:
8.2.1.1
22.6.1.4, 22.7.1.2, 22.7.1.3

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

22.12.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.

Where the documentation (patient record) audit is a hospital-wide multidisciplinary process that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.
Linked criteria:
8.2.1.5

22.13 Patient Rights

22.13.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

22.13.1 Criteria

22.13.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

This applies to all the relevant criteria below.
Linked criteria:
5.1.1.3
22.10.1.2

22.13.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
4.1.1.6
5.2.1.1-3
6.1.2.1
22.2.1.2

22.13.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

22.14 Prevention and Control of Infection

22.14.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

22.14.1 Criteria

22.14.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

Root criterion
The department participates in, and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation wide infection control processes.

Linked criterion:
9.2.1.1

22.14.1.2 Infection control processes include prevention of the spread of respiratory tract infections.

22.14.1.3 Infection control processes include prevention of the spread of urinary tract infections.

22.14.1.4 Infection control processes include prevention of the spread of infection through intravascular invasive devices.

22.14.1.5 Infection control processes include prevention of the spread of infection through surgical wounds.

22.15 Risk Management

22.15.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

22.15.1 Criteria

22.15.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks. should be included.

Linked criterion:
7.1.1.1

22.15.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
22.9.2.5 and 6

22.15.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

22.15.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

22.15.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 23 OUTPATIENT CARE

OVERVIEW OF OUTPATIENT CARE

Outpatient care may be an integral part of the continuum of care provided before or after a period of hospitalisation, or may be provided to a patient, who is referred from a community-based organisation. In some organisations, outpatient care may be considered an independent, comprehensive service encompassing all outpatient visits.

The World Health Organisation (WHO) has outlined a framework for primary health care, which includes preventive, promotive, curative, rehabilitative and supportive components. Community Health Service programmes encompasses these five components, within the continuum of health for local communities. A comprehensive referral network with other community agencies supports continuity of care in terms of primary health services, outpatient care at a local hospital, educational services and social services.

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, assessing patients to monitor the results of care, modifying care when necessary and completing the follow up.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, laws and regulations, an individual's particular skills, knowledge and experience, and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medications, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Continuity of care:
From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation.

Processes, for continuity and coordination of care among medical practitioners, nurses and other health providers, must be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure coordination of care.

Standards

23.1 Coordination of Patient Care

23.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

23.1.1 Criteria

23.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers, i.e. doctors and nurses.

Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists.

It is important to assess the availability of doctors, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
2.2.1.1
2.5.1.1

23.1.1.2 The individuals responsible for the patient's care are qualified and registered with the relevant regulatory or professional body.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels .

Personnel assisting in the provision of emergency services are appropriately qualified, trained and supervised and are available in sufficient numbers for the emergency services provided.

The level of qualifications required would be dependent on the category of the relevant hospital.

Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
23.4.1.2, 23.7.1.1, 23.7.2.1

23.1.1.3 The individuals responsible for the patient's care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times. ***Patient interviews*** *will reveal whether staff members introduce themselves to patients.*

Linked criterion:
23.6.1.3

23.1.1.4 During the hours of operation there are an adequate number of qualified professionals available to provide continuous cover to all sections at all times.

Critical criterion
Linked criterion:
2.2.1.5

23.1.1.5 Medical cover is reflected on a roster and each practitioner on the roster is contactable by telephone or pager, or other two-way communication method.

23.1.1.6 Arrangements are in place to assure that specialist consultation services are available.

These specialists do not necessarily need to be on site for all levels of care, but must be contactable by telephone.

23.1.1.7 Mechanisms for contacting medical practitioners who treat private patients in the hospital are known to personnel (with contact numbers of the patient's medical practitioner or their available partners or locums).

23.1.2 The delivery of services is integrated and co-ordinated amongst care providers.

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team delivered care, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate. The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

A patient benefits most when the personnel responsible for the patient work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established and care decisions are made.

23.1.2 Criteria

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

Root criterion

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 criterion:
1.3.2.4

23.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (doctors, nurses, professions allied to medicine, social workers, etc.) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record.

Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

Compliance will be verified during the ***patient record audit.*** *If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.*

The expectation is that patient records are available at the facility. This ensures continuity of care, exchange of information and confidentiality. However, national requirements must be taken into account. Where there are patient held records (cards/books), these must be assessed on site i.e. during patient interviews in the outpatient department. The score will be assigned according to the information found in the records i.e. the completeness of the records.

Linked criterion:
23.4.1.1

23.1.2.3 Information exchanged includes a summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.*** *If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.*

23.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

23.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.
Methods of verifying signatures and designations could include:

- *names and designations printed below signatures*
- *stamps indicating names and designations and/or*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

23.1.2.6 The date of each patient record entry can be identified.

Records must follow a chronological order to allow for a logical flow of information.
Compliance will be verified during the ***patient record audit.***

23.1.2.7 The time of each patient record entry can be identified.

Patient records include time of arrival at the facility and each time that the patient is assessed by a health professional.

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

23.1.3 *There is a system to ensure that patients are seen within the shortest possible time.*

Standard Intent

Patients have the right to be attended to within the shortest possible time. There is an appointment system, and patients who are waiting, are advised of any delays that may be experienced in receiving attention. The waiting times are monitored as part of the organisation's quality management and improvement programme. Patients requiring urgent care are identified and attended to immediately.

23.1.3 Criteria

23.1.3.1 There is a screening process to separate those patients requiring urgent and emergency care from those requiring on-going routine outpatient services.

On arrival at the facility the patient requiring emergency care is immediately sent to the resuscitation area for formal triaging i.e. they do not follow the usual process of registering etc.

Linked criterion:
4.2.2.4

23.1.3.2 There is a process of registration for outpatient care and treatment.

Linked criterion:
4.2.2.1

23.1.3.3 The register contains at least the patient's name, patient specific identification number, age, gender, date and time of admission, treatment, procedures, condition at discharge, referral or death.

The criterion is specific about what must (<u>at least</u>) be recorded. Other items can be included in the guideline as nice to have.

23.1.3.4 There is a clearly defined appointment system for routine on-going out patient care.

23.1.3.5 There is a system for fast tracking the very ill, the elderly and frail, pregnant women and children under five years of age.

Critical criterion

Patients with special needs must be prioritised, according to established criteria, for assessment and intervention. These patients have not been identified during the initial screening process as requiring formal triage, but cannot be expected to wait for long periods for attention.

Linked criterion:
4.2.2.4

23.1.3.6 Patients who are waiting are advised of any delays that may be experienced in receiving attention.

23.1.3.7 Waiting times are monitored as part of the organisation's quality management and improvement programme.

Linked criterion: 23.10.1.2

23.2 Facilities and Equipment

23.2.1 Adequate resources are available for the provision of safe care to patients in the ward.

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate ablution facilities for the number of patients in the unit, as determined by national legislation.
There is adequate lighting and ventilation.

Emergency call systems, which are connected to the emergency power supply, in ablution facilities and consulting rooms should be considered.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily.

23.2.1 Criteria

23.2.1.1 Patient and staff accommodation in the service is adequate to meet patient care needs.

Root criterion. *There should be adequate office space for personnel; clean, hygienic sluice rooms, treatment and dressing rooms; adequate, tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients, as well as the requirements mentioned below.* *Linked criteria:* *1.2.2.3* *4.2.2.6*

23.2.1.2 Facilities allow privacy when providing personal information, or undergoing examination or procedures.

Linked criterion: *23.11.1.2*

23.2.1.3 Electricity and water is available in accordance with the policies of the organisation.

Ward/unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

23.2.1.4 There is a waiting area for patients and families.

23.2.1.5 There is adequate seating in the waiting area.

23.2.1.6 Wheelchair accessible toilets are available.

Linked criterion:
4.2.1.4

23.2.1.7 There is access to a functioning telephone facility for use by the public.

23.2.2 *Clinical areas within the outpatient department are adequate to meet the needs of patients*.

Standard Intent

In situations of limited resource most outpatient departments will not be located in a modern, purpose built facility. However, the clinical areas may be arranged in a way that assists management of the most patients.

Resuscitation equipment is immediately available from each section of the department. Resuscitation equipment includes at least:

- A defibrillator with adult paddles / pads (and infant paddles / pads where applicable)
- An ECG monitor
- A CPR board (if required)
- Suction apparatus(electrical and/or alternative) plus range of soft and hard suction catheters
- A bag-mask manual ventilator
- Range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable
- Introducer /stylet for endotracheal intubation
- Syringe to inflate ETT cuff
- Oropharyngeal tubes
- Equipment to perform an emergency crico-thyroidotomy
- Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- Drugs for cardiac arrest, coma, fits and states of shock (including paediatric doses)
- Plasma expanders
- Pulse oximeter.

23.2.2 Criteria

23.2.2.1 There is a mechanism for the summoning of medical help in an emergency.

Critical criterion

This refers to the summoning of medical help both from within the unit itself and from other departments within the facility.

Refer to guideline from 24.2.2.2

Linked criterion:
1.2.2.3

23.2.2.2 Resuscitation equipment is available in accordance with the policies of the organisation.

Critical criterion

Must include at least the items mentioned in the Intent statement and according to national requirements

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

Linked criterion:
30.2.1.2

23.2.2.3 Oxygen and vacuum supplies meet patient care needs.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. There must also be enough functional flow meters.

Any evidence of infection control deficiencies e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9

Linked criterion:
29.2.2.1

23.2.2.4 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

Linked criterion:
23.4.1.1

23.2.2.5 Diagnostic and vital sign monitoring equipment is available as per organisational policy.

Basic vital sign measurement, ECG (where appropriate), Dynamaps, peak flow meters, etc.

Diagnostic "point of care" or "bedside" tests are performed within the emergency unit by non laboratory staff and give rapid results. They are particularly important where laboratory facilities are not available on the premises; transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the emergency unit. Personnel are trained in the use of diagnostic equipment and quality controls are in place for all diagnostic equipment.

The following are required as a minimum. Equipment for:

- *determination of blood glucose levels*
- *finger-prick haemoglobin or haematocrit testing*
- *urine testing*
- *Falciparum malaria testing (in areas where malaria is endemic, or where tourists are frequently seen)*
- *blood gas analysis (this should include lactate measurements if required by organisation policy).*

23.2.2.6 There is adequate storage space to enable rapid retrieval and removal of equipment when needed.

23.2.2.7 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture as beds.

Linked criterion:
31.2.1.5

23.2.2.8 There is access to inpatient facilities consistent with the level of care.

Linked criterion:
4.1.1.10

23.3 Clinical Practice Guidelines

23.3.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, and standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and

high cost conditions as these will form the basis for structured clinical audits. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

23.3.1 Criteria

23.3.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

Guidelines/protocols "relevant to the patients and services" are assessed in each department according to the disease profiles of the patients admitted. Doctors and nurses follow National Clinical Practice Guidelines.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

In the absence of guidelines, this criterion will be scored NC.

Linked criterion:
1.3.2.1

23.3.1.2 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criteria:
8.2.1.4
23.10.1.2

23.3.1.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

23.4 Assessment of Patients

23.4.1 *All patients cared for by the organisation have their health needs identified through an established assessment process.*

Standard Intent

When a patient enters an outpatient department, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs

and on the setting in which care is being provided.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations. These findings are used throughout the care process to evaluate patient progress and provide information regarding the need for re-assessment. It is essential that assessments are well documented and can be easily retrieved from the patient's record.

The health organisation determines the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

23.4.1 Criteria

23.4.1.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care

Root criterion

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy.

Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

Time frames for the assessment of patients need to be established for each discipline e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

Linked criterion:
1.2.6.1

23.4.1.2 Only those individuals permitted by applicable laws and regulations or by registration appropriate training/experience perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of notes made in the patient record by the doctor or relevant clinical personnel other than nurses will affect the outcome of the audit process.*

Linked criteria:
23.1.1.2, 23.1.2.4

23.4.1.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline. These forms should include at least

- *history*
- *physical examination*
- *vital signs*
- *psycho-social assessment, where applicable;*
- *provisional diagnosis*
- *diagnostic procedures*
- *treatment planning*

The absence of medical notes or notes by relevant clinical personnel, other than nurses, in the patient record will affect the outcome of the audit process.

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

23.4.1.4 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

Linked criterion:
23.1.2.2

23.5 Diagnostic Services

23.5.1 Diagnostic imaging services are available to meet patient needs.

Standard Intent

The organisation leaders ensure that appropriate diagnostic imaging facilities are available, that there are radiation safety programmes in place, and that individuals with adequate training, skills, orientation and experience are available to undertake X-ray procedures and interpret the results.

The diagnostic imaging service allows for immediate decision-making by practitioners through the provision of emergency services and the provision of emergency reports as necessary.

23.5.1 Criteria

23.5.1.1 Adequate and convenient diagnostic imaging services are available during hours of operation.

It is important to note that this criterion addresses a number of issues.

"Adequate" one should take into consideration the level of service that is required e.g. does the Tertiary hospital provide a CAT scan, is there a Radiologist.

The service should meet the needs of the population that it serves e.g. if the service is only available 2 or 3 days per week, but the need is there for a daily service, then this would warrant a PC score.
If equipment is broken or supplies are lacking, or staff are inadequate and the full scope of service (as required) cannot be rendered then the criterion should be scored down.

"Convenient" refers to the patient's experience and it should be considered that sometimes patients are referred "unnecessarily" somewhere else because of staff shortage, broken equipment, lack of supplies, etc. Or they have to be admitted on Saturday to wait for X-rays on the Monday, in which case this criterion will be scored down.

Where SE 20 forms part of the assessment at the facility the identified linked criteria will apply.

This criterion should be scored similarly to criterion 20.1.1.1 in SE 20 Diagnostic Radiology and Imaging services.

Linked criteria:
1.2.2.3, 1.2.7.2

23.5.1.2 Established waiting times for diagnostic imaging studies to be done, according to triage status, are monitored.

Linked criterion:
23.10.1.2

23.5.1.3 Established waiting times for diagnostic images to be available are monitored.

Linked criterion:
23.10.1.2

23.5.1.4 Where X-rays are initially read by emergency unit medical staff, there is a clearly defined system for review by appropriately qualified diagnostic imaging staff, when required.

Linked criterion:
20.1.3.4

23.5.2 *The outpatient department is adequately supported by clinical laboratory services.*

Standard Intent

This set of standards recognises that many centres will rely on external laboratory facilities; in this situation, services, transport systems and expected time for results should be established.

Whatever the arrangement, it is expected that laboratory services will be available 24/7 and should be on site or in close proximity to the emergency unit.

Point of care" or "bedside" tests are performed within the outpatient department by non-laboratory staff and give rapid results. They are particularly important where laboratory facilities are not available on the premises; transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the emergency unit. Determination of blood glucose, either finger-prick haemoglobin or haematocrit testing; and urine testing are considered essential for an outpatient department. Centres in areas where malaria is endemic, or where tourists are frequently seen, should also have rapid, antigen based tests for the diagnosis of Falciparum malaria. Training and quality control are required for all point of care tests.

The majority of urgent clinical decisions can be made based on the results of point of care testing outlined above; however, emergency centres require urgent laboratory services for the provision of specialised testing.

23.5.2 Criteria

23.5.2.1 Laboratory services are available during hours of operation.

Where SE 19 forms part of the assessment at the facility the identified linked criteria will apply.

This criterion should be scored similarly to criterion 19.1.1.1 in SE 19 Laboratory service.

Linked criterion:
1.2.3.3, 1.2.7.2

23.5.2.2 Established waiting times for laboratory tests to be done, according to triage status, are monitored.

Linked criterion:
23.10.1.2

23.5.2.3 Established waiting times for laboratory results to be available are monitored.

Linked criterion:
19.2.3.1
23.10.1.2

23.6 Patient Care

23.6.1 *Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.*

Standard Intent

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent, for example verbally, by signing a consent form, or through some other mechanism.

Patients and families understand who may, in addition to the patient, give consent. Designated staff is trained to inform patients and to obtain and document patient consent. These staff members clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications
- consideration of the surgical and non-surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written informed consent. Leaders document the processes for the obtaining of informed consent.

The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledged full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

23.6.1 Criteria

23.6.1.1 There is a documented process for the obtaining of informed consent.

Root criterion.
This section refers to all instances where patients give informed consent and compliance will be verified during the ***patient record audit****.*

If consent was not required for the patient records audited, this whole standard becomes NA.

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 23.6.1.4 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC because the process has not been implemented.

Linked criteria:
5.6.1.1
23.11.1.1

23.6.1.2 Patients are informed about their condition, and the proposed treatment.

23.6.1.3 Patients know the identity of the physician or other practitioner responsible for their care.

This will be assessed during ***patient interviews.***

Linked criterion:
23.1.1.3

23.6.1.4 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion

*Compliance will be verified during the **patient record audit.***
If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information as indicated in the relevant criteria above. This criterion and the relevant criteria above will be scored C.

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria above will receive the same score.

Linked criterion:
23.6.1.1

23.6.2 *Minor invasive procedures performed in the outpatient department are controlled by policy.*

Standard Intent

Patients attending the outpatient department may require invasive procedures such as biopsies, aspirations.

Policies are required to define who should be doing these procedures, to ensure that they are performed based on clinical need and to control sterility of the procedure. Persons performing invasive procedures are appropriately trained.

Adverse events resulting from invasive procedures should be documented.

23.6.2 Criteria

23.6.2.1 Protocols guide medication use for sedation, pain and anaesthesia.

Linked criterion:
23.7.1.1

23.6.2.2 Protocols address appropriate monitoring during and after the procedure.

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

23.6.2.3 The procedure and the name of the person performing the procedure are recorded in the patient's record.

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

23.6.3 *The organisation implements processes to support the patient in managing pain*

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported. The organisation has processes to:

- identify patients with pain during initial assessment and reassessment
- communicate with, and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs
- educate health service providersin pain assessment and management.

23.6.3 Criteria

23.6.3.1 The assessment process makes provision for patients in pain to be identified.

23.6.3.2 Patients in pain receive care according to pain management guidelines.

Critical criterion

There should be evidence that all clinical professionals dealing with the patient's pain management, have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow up assessment after treatment

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

Linked criteria:
1.3.2.2
23.3.1.2

23.6.3.3 Patients and families are educated about pain and pain management.

*Compliance will be verified during the **patient record audit and patient interviews.***

23.6.3.4 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:

2.4.2.2

23.7 Medication

23.7.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

23.7.1 Criteria

23.7.1.1 Policies and procedures that guide the safe prescribing, ordering, storage and administration of medications are implemented.

Root criterion for all criteria in standards 23.7.1., 23.7.2 and 23.7.3

These policies need to be developed by all the role-players, i.e. medical practitioners, nurses and pharmacists.

National regulations will apply, e.g. registered nurses are permitted to prescribe medication in a hospital setting..

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

Linked criteria:
1.3.2.1
21.1.2.1, 21.3.1.1
23.1.1.2

23.7.1.2 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
21.3.1.1
23.7.2.3

23.7.1.3 Only those permitted by the organisation and by relevant laws and regulations prescribe medication.

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

Linked criteria:
21.2.1.1 to 21.2.1.5
23.1.1.2

23.7.1.4 Medications, including herbal, tradional and over the counter medications, brought into the organisation by the patient or the family are known to the patient's doctor and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over the counter and homeopathic medicines.

These should be represcribed on the prescription sheet if indicated.

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

23.7.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, doctor , nurse, and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed~~,~~ and to evaluate the patient for adverse effects.

The organisation follows national requirements for the reporting of adverse effects. Doctors, nurses, and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

23.7.2 Criteria

23.7.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:

23.1.1.2

23.7.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

23.7.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
21.3.1.1
23.7.1.2

23.7.2.4 Health professionals monitor medication effects on patients collaboratively.

***Patient record audits** should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the doctor*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional information may be required for e.g., plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

23.7.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

*An **adverse drug reaction** (abbreviated **ADR**) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also*

imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.

Compliance is verified during the ***patient record audit.***
Documentation showing that the reaction was reported to the physician and the pharmacist will be sought.

Linked criteria:
7.1.1.7
21.6.1.1
23.13.1.2

23.7.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording ~~of~~ medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
21.6.1.1
23.13.1.2

23.7.2.7 The medications prescribed for and administered to each patient are recorded.

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

23.7.2.8 Where prescribed medications are not available for administration, this is noted in the patient record.

23.7.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

23.7.3 Criteria

23.7.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerators, etc.) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant staff members only.

An unlocked refrigerator in an unlocked room will be scored NC.

Linked criterion:
21.5.1.10

23.7.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

National -specific laws and regulations or organisational policy will determine the nature of these medications.

23.7.3.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion

Compliance needs to be measured against the local medicine control regulations. Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

23.7.3.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion

National specific regulations apply, but must include at least the following:

- *name of unit and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number and*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

23.7.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

Linked criterion:
21.5.1.7

23.7.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

23.7.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication.

Linked criterion:
21.5.1.9

23.7.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion

Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

23.7.3.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

23.8 Patient and Family Education

23.8.1 Each patient receives relevant education, which is written in his or her record.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care, and continue care at home.

Variables like educational literacy, beliefs and limitations are taken into account. Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administration, they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.

Community organisations that support health promotion and disease prevention education are identified and, when possible, on-going relationships are established.

*Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.*

23.8.1 Criteria

23.8.1.1 Patients and families indicate that they have been informed about their diagnosis.

23.8.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2
23.11.1.1

23.8.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use, etc.

23.8.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

23.9 Continuity of Care

23.9.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providersmay be involved in providing care. Without Coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

23.6.1 Criteria

23.9.1.1 Established criteria or policies that determine the appropriateness of transfers within the organisation are implemented.

Root criterion

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

23.9.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

23.9.1.3 Continuity and Coordination are evident throughout all phases of patient care.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

23.9.1.4 The record of the patient accompanies the patient when transferred within the organisation.

23.9.2 There is a process for admitting patients to in-patient facilities.

Standard Intent

The time that patients spend waiting for transfer to in-patient facilities should be minimised. Not only is this in the interest of patients' comfort and definitive management, but long holding times have a significant impact on the functioning of the emergency centre, using space, resources and nursing time. Admission delays are often the result of system failures and processes should be designed to deal with this. The emergency centre can become congested when there is a lack of in-patient beds. Certain strategies may be implemented to manage inpatient beds more efficiently, such as more frequent consultant ward rounds, and "escalation policy" to address periods of particular overcrowding can be developed in advance with in-patient personnel.

23.9.2 Criteria

23.9.2.1 There is a process, known to staff, for admitting patients to the organisation.

Root criterion
Linked criterion:
4.2.2.2

23.9.2.2 The unit which accepts the patient for admission is noted in the patient record.

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

23.9.2.3 The time of transfer is recorded.

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

23.9.2.4 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.

Linked criterion:
4.2.2.6

23.9.3 There is a process known to staff to appropriately refer patients for specialised consultation/investigations at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialized treatment that the referring organisation may be unable to provide. The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

23.9.3 Criteria

23.9.3.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.

*Compliance for this criterion and the following will be verified during the **patient record audit.***

Linked criterion:
1.2.5.4

23.9.3.2 A copy of the referral note is available in the patient record.

23.9.3.3 Follow-up care, based on the findings of investigations/consultations performed outside the organisation, is noted in the patient record.

23.9.4 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation at another health facility for treatment, urgent services, or for less intensive services such as sub-acute care or long term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient.

Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

In a well organised system, the capabilities of individual organisations will be catalogued and coordinated, so that arrangements will already exist with units to which the facility frequently refers. When transfer criteria and processes are formally agreed in advance, patients are more likely to receive appropriate emergency care when their needs exceed the capabilities of the facility.

To ensure continuity of care, adequate information must accompany the patient.

Transfer may be a brief process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

Appropriate information should accompany the patient, including at least:

- The reason for transfer
- Any special conditions related to transfer
- The condition of the patient before transfer
- Any interventions provided by the referring organisation.

23.9.5 Criteria

23.9.5.1 There is a documented process for transferring patients to other organisations.

Root criterion
Linked criteria:
1.2.5.4
4.1.1.10
23.9.4.6

23.9.5.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

23.9.4.3 The process for transferring the patient considers transportation needs.

Available transport for emergency patients and non-emergency patients will depend on national arrangements and what is reasonable. If specific norms exist, these can be included; otherwise it becomes non-implementable and non-compliant.

23.9.4.4 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

Linked criterion where the organisation operates its own ambulance service.
3.4.2.4

23.9.4.5 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

23.9.4.6 A copy of the transfer summary is available in the patient record.

Critical criterion

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
23.9.4.1

23.9.4.7 The health organisation agreeing to receive the patient is noted in the patient's record.

23.9.5 There is an organised process to appropriately discharge patients who no longer require treatment or follow-up care at the facility.

Standard Intent

The organisation begins to plan for the patients' continuing needs as early in the care process as possible. Instructions for discharge and follow up care at another facility e.g. primary health clinic must be clear and provided in writing.

The discharge note is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

The note contains at least

- the diagnosis of main and significant illnesses.
- the results of investigations that will influence further management
- all procedures performed
- the patient's condition at discharge
- discharge medications and follow-up arrangements.

23.9.5 Criteria

23.9.5.1 There is a documented process to appropriately discharge patients.

Root criterion *Linked criterion:* *1.2.5.4*

23.9.5.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

*Compliance for this criterion and the following will be verified through **patient record audits**.*

23.9.5.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow up instructions may be provided to the patient by the doctor or by the nurse, following instructions from the doctor. *The instructions should include medications, wound care, possible complications, return for follow-up care, when and where to obtain urgent care, etc.*

23.9.5.4 A discharge note which includes at least items a) to e) in the intent statement, is written by the medical practitioner when each patient is discharged.

23.9.5.5 Each record contains a copy of the discharge summary.

23.10 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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 for quality monitoring and improvement.

Quality monitoring could include:

a) patient assessment
b) the use of antibiotics and other medications and medication errors the availability, contents and use of patient records
c) waiting times
d) patient and family expectations and satisfaction

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.

A once off project such as acquiring a specific item of equipment, will be scored NC. Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

23.10.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

23.10.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings or specialised investigative studies. An indicator, in this context, is a measure used to determine improvements in clinical care over time.

The information gained must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

Linked criterion:
8.2.1.1
23.1.3.7

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

23.10.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.
Where the documentation (patient record) audit is a hospital wide multidisciplinary process that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.
Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

23.11 Patient Rights

23.11.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

23.11.1 Criteria

23.11.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable.
Implementation the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

This applies to all the relevant criteria below.

Linked criteria:
5.1.1.3
23.8.1.2

23.11.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
4.1.1.6
5.2.1.1-3
6.1.2.1
23.2.1.2

23.11.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

23.12 Prevention and Control of Infection

23.12.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

23.12.1 Criteria

23.12.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

Root criterion

The department participates in, and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.

Take note of the relevant criteria in standards 9.1.2 and 9.2.1

Linked criterion:
9.2.1.1

23.12.1.2 Infection control processes include prevention of the spread of respiratory tract infections.

23.12.1.3 Infection control processes include prevention of the spread of urinary tract infections.

23.12.1.4 Infection control processes include prevention of the spread of infection through intravascular invasive devices.

23.12.1.5 Infection control processes include prevention of the spread of infection through surgical wounds.

23.13 Risk Management

23.13.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

23.13.1 Criteria

23.13.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial, and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

23.13.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4
23.7.2.5 and 6

23.13.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

23.13.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

23.13.1.5 The organisation's policy on handling, storing and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 24 COMBINED OUTPATIENT AND EMERGENCY SERVICE

OVERVIEW OF COMBINED OUTPATIENT AND EMERGENCY SERVICE

This chapter is intended to be used by organizations that do not have separate outpatient and emergency departments. Usually in smaller institutions, these services can be provided in the same department, by the same staff. Emergency cases are handled as they occur, with minimal disruption of the outpatient service.

Outpatient care is care and treatment provided on an outpatient basis and does not include a stay of longer than 24 hours. Outpatient care may be an integral part of the continuum of care provided before or after a period of hospitalisation, or may be provided to a patient, who is referred from a community-based organisation. In some organisations, outpatient care may be considered an independent, comprehensive service encompassing all outpatient visits.

Emergency care is provided at many different levels and, clearly, the expectations in terms of expertise and equipment are different. These standards are deliberately not prescriptive about the physical facilities. Although optimisation of the physical environment is an important goal, excellent care can be provided with limited resources.

A health organisation's main purpose is patient care. Providing the most appropriate care, in a setting that supports and responds to each patient's unique needs, requires a high level of planning and coordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, assessing patients to monitor the results of care, modifying care when necessary and completing the follow up.

Many medical, nursing, pharmaceutical, rehabilitation and other types of health service providersmay carry out these activities. Each provider has a clear role in patient care. Credentialing, registration, laws and regulations, an individual's particular skills, knowledge and experience, and organisational policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medications, supportive therapies, or a combination of these. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

From entry to discharge or transfer, several departments, services and different health service providersmay be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. This is accomplished by using established criteria or policies, which determine the appropriateness of transfers within the

organisation.

Processes, for continuity and Coordination of care among physicians, nurses and other health providers, must be implemented in and between all services. Leaders of various settings and services work together, to design and implement the required processes, and thus ensure Coordination of care.

Standards

24.1 Coordination of Patient Care

24.1.1 During all phases of care, there are qualified individuals responsible for the patient's care.

Standard Intent

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to the personnel.

24.1.1 Criteria

24.1.1.1 The individuals responsible for the patient's care are designated.

The focus is on the "core" care-givers, i.e. doctors and nurses.

Evidence is required in the form of staff allocation lists, duty rosters and off-duty lists. It is important to assess the availability of doctors, especially after-hours cover, including week-ends and public holidays.

Linked criteria:
1.2.7.2
2.2.1.1
2.5.1.1

24.1.1.2 The individuals responsible for the patient's care are qualified and registered with the relevant regulatory or professional body.

The lists mentioned above must be examined for evidence of adequate numbers of the various categories of personnel, related to the type of patients, acuity levels etc.

Personnel assisting in the provision of emergency services are appropriately qualified, trained and supervised and are available in sufficient numbers for the emergency services provided.

The level of qualifications required would be dependent on the category of the relevant hospital. Proof of current registration with the relevant authority, where applicable, must be available.

Linked criteria:
2.2.1.1, 2.5.1.1
24.6.2.2, 24.9.1.1, 24.9.2.1

24.1.1.3 The individuals responsible for the patient's care are identified and made known to the patient and other personnel.

Name badges should be worn by all staff members at all times.
Patient interviews *will reveal whether staff members introduced themselves to patients.*

Linked criterion:
24.8.1.4

24.1.1.4 During the hours of operation there is an adequate number of qualified professionals available to provide continuous cover to all sections at all times.

Root criterion for criteria 24.1.1.5 to 7
Linked criterion:
2.2.1.5

24.1.1.5 Medical cover is reflected on a roster and each practitioner on the roster is contactable by telephone or pager, or other two-way communication method.

24.1.1.6 Arrangements are in place to assure that adequate specialist consultation services are available.

These specialists do not necessarily need to be on site for all levels of care, but must be contactable by telephone

24.1.1.7 Mechanisms for contacting doctors who treat private patients in the hospital are known to staff (with contact numbers of the patient's doctor or their available partners or locums).

24.1.2 *The delivery of services is integrated and co-ordinated amongst care providers.*

Standard Intent

The Coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by organisational policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers). The process for working together will be simple and informal when the patient's needs are not complex.

The patient, family and others are included in the decision process when appropriate. The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team, and is made available to all relevant caregivers who are authorised to have access to its content.

A patient benefits most when the personnel responsible for the patient work together

to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established, and care decisions are made.

24.1.2 Criteria

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

Root criterion

This refers to the relevant forms/documents that need to be present in the patient's clinical record, as well as the completeness of entries made. For this purpose, the results ***of patient record audits*** *need to be taken into account. The score of this criterion needs to reflect the aggregated average score of all relevant criteria in this document.*

Linked criterion:
1.3.2.4

24.1.2.2 The patients' records are up to date to ensure the transfer of the latest information between care providers.

Clinical professionals (doctors, nurses, professions allied to medicine, social workers, etc.) form part of the multidisciplinary /interdisciplinary team and contribute to the patient record.

Records of multidisciplinary/interdisciplinary team meetings need to be documented as evidence of integrated care. All patient care information will be obtained from notes made by each member of the above team. The clinical involvement of medical practitioners must be measured in all relevant sections of the service.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow-up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily. Whether the records are kept at the bedside or some other location, they must be available to all care providers to enable them to make the necessary notes and/or check information.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

Linked criterion:
24.6.2.1

24.1.2.3 Information exchanged includes a summary of the care provided.

The notes in the patient record will indicate whether the patient has been assessed (initial, repeat, follow up) by the relevant care givers at intervals appropriate to the patient's condition and whether these assessments have been recorded satisfactorily.

Enough information must be available for other members of the team to continue with or to make informed decisions regarding the care of the patient. Establish whether the instructions given were actually carried out.

Compliance will be verified during the ***patient record audit.***
If the notes of doctors and other health professionals are not available because they are kept separately in another location, this criterion will be scored PC.

24.1.2.4 Information exchanged includes the patient's progress.

The patient records must clearly indicate what was found on admission, what interventions took place and the patient's response to those interventions.

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

24.1.2.5 The author can be identified for each patient record entry.

In order to ensure that appropriately qualified individuals provide patient care and record their activities related to that care, signatures and designations must be recorded and the authors must be identifiable.

Methods of verifying signatures and designations could include:
- *names and designations printed below signatures*
- *stamps indicating names and designations and/or*
- *specimen signature lists in the patient records or in the relevant department.*

The specimen signature lists must be up to date and include all relevant signatures and initials. Specimen signatures and initials must match the usual signatures and initials used in patient records. If signature lists are used, they are to be archived for future reference.

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

If the signatures and designations cannot be matched to any of the systems mentioned above, this criterion will be marked PC or NC based on audit results.

24.1.2.6 The date of each patient record entry can be identified.

Records must follow a chronological order to allow for a logical flow of information.
Compliance will be verified during the ***patient record audit.***

24.1.2.7 The time of each patient record entry can be identified.

Patient records include time of arrival at the facility and each time that the patient is assessed by a health professional.

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

24.1.3 There is a system to ensure that patients are seen within the shortest possible time.

Standard Intent

Patients have the right to be attended to within the shortest possible time. There is an appointment system, and patients who are waiting, are advised of any delays that may be experienced in receiving attention. The waiting times are monitored as part of the organisation's quality management and improvement programme. Patients requiring urgent care are identified and attended to immediately.

24.1.3 Criteria

24.1.3.1 There is a screening process to separate those patients requiring urgent and emergency care from those requiring on-going routine outpatient services.

On arrival at the facility the patient requiring emergency care is immediately sent to the resuscitation area for formal triaging i.e. they do not follow the usual process of registering etc.

Linked criterion:
4.2.2.4

24.1.3.2 Those patients identified as requiring emergency care are formally triaged according to organisational policy.

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

Linked criterion:
24.6.1.2
24.6.2.1

24.1.3.3 There is a process of registration for outpatient care and treatment.

Linked criterion:
4.2.2.1

24.1.3.4 The register contains at least the patient's name, patient specific identification number, age, gender, date and time of admission, diagnosis, treatment, procedures, condition at discharge, referral or death.

24.1.3.5 There is a clearly defined appointment system for routine on-going out patient care.

24.1.3.6 There is a system for fast-tracking the very ill, the elderly and frail, and pregnant women and children under five years of age.

Critical criterion

Patients with special needs must be prioritised, according to established criteria, for assessment and intervention. These patients have not been identified during the initial screening process as requiring formal triage, but cannot be expected to wait for long periods for attention.

Linked criterion:
4.2.2.4

24.1.3.7 Patients who are waiting are advised of any delays that may be experienced in receiving attention.

24.1.3.8 Waiting times are monitored as part of the organisation's quality management and improvement programme.

Linked criterion:
24.12.1.2

24.2 Facilities and Equipment

24.2.1 Adequate resources are available for the provision of safe care to patients in the unit.

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for staff, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. There are adequate toilet and bathing facilities for the number of patients in the ward, as determined by national legislation.

There is adequate lighting and ventilation.

Emergency call systems are available in consulting rooms and in bathrooms and toilets and are connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, there are mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction are in place and working satisfactorily. Each room is provided with a socket outlet that is connected to the emergency power supply.

24.2.1 Criteria

24.2.1.1 Patient and staff accommodation in the service is adequate to meet patient care needs.

Root criterion

There should be adequate office space for personnel; clean, hygienic sluice rooms, treatment and dressing rooms; demonstration room, adequate, tidy linen and equipment storage facilities; suitable lighting and ventilation; adequate, hygienic bathroom and toilet facilities for the number of patients, as well as the requirements mentioned below.

Linked criteria:
1.2.2.3
4.2.2.6

24.2.1.2 Facilities allow privacy when providing personal information, or undergoing examination or procedures.

Linked criterion:
24.13.1.2

24.2.1.3 Electricity and water is available in accordance with the policies of the organisation.

Ward/unit personnel need to know the routine arrangements and the contingency plans.

Linked criteria:
29.3.1.1, 29.3.1.5

24.2.1.4 There is a waiting area for patients and families.

24.2.1.5 There is adequate seating in the waiting area.

24.2.1.6 Wheelchair accessible toilets are available.

Linked criterion:
4.2.1.4

24.2.1.7 Quiet and private areas are available for waiting relatives and grieving or otherwise distressed relatives or carers.

24.2.1.8 There is access to a functioning public telephone facility for use by the public.

24.2.2 *Clinical areas within the outpatient/emergency department are adequate to meet the needs of patients.*

Standard Intent

In situations of limited resources most outpatient departments will not be located in a modern, purpose built facility. However, the clinical areas may be arranged in a way that assists management of the most critical patients. There should be a designated resuscitation area.

24.2.2 Criteria

24.2.2.1 There is a designated resuscitation area.

24.2.2.2 There is a mechanism for the summoning of medical help in an emergency.

This refers to the summoning of medical help both from within the unit itself, from other departments within the facility or from outside the hospital.

Various methods such as an alarm, intercom, alert button, besides functional telephone/pager systems are acceptable.

Linked criterion:
1.2.2.3

24.2.2.3 Oxygen and vacuum supplies meet patient care needs.

There should be either piped oxygen/vacuum or mobile oxygen cylinders and vacuum pumps in working order to meet the patients' needs. There must also be enough functional flow-meters.

Any evidence of infection control deficiencies e.g. stagnant water in humidifiers/vacuum bottles will be linked to SE 9

Linked criterion:
29.2.2.1

24.2.2.4 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are monitored according to organisational policy while patients are receiving oxygen.

Critical criterion

Linked criteria:
22.2.3.1
22.6.2.1

24.2.2.5 There is adequate storage space to enable rapid retrieval and removal of equipment when needed.

24.2.2.6 There is evidence that equipment is maintained in accordance with the policies of the organisation.

This refers to medical equipment and not to furniture such as beds.

Linked criterion:
31.2.1.5

24.2.2.7 Each patient in the emergency unit has access to a nurse call system at all times.

A functional nurse call system is available at each patient's bed and in the ablution facilities. Random tests can be conducted to assess function and response. Assess whether responses are effective by interviewing patients and reviewing patient complaints.

This criterion will be scored accordingly, e.g. NC if there is no functional call system and PC if nurses do not respond.

Linked criterion:
29.2.1.2

24.2.2.8 There is a low pressure, handheld shower suitable for the management of patients contaminated with hazardous materials.

24.2.2.9 There is access to in-patient facilities consistent with the level of care.

Linked criterion: *4.1.1.10*

24.2.3 Resuscitation equipment is available in accordance with the policies of the organisation.

Standard Intent

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

A resuscitation trolley should be available at the point of need within 1 minute. In addition there is access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any patient collapsing.

It is important to carry a range of adult and paediatric size equipment and a reasonable selection within each range. National arrangements will apply.

Resuscitation equipment is immediately available from each section of the ward. Resuscitation equipment includes at least:

- A defibrillator with adult paddles / pads (and infant paddles / pads where applicable)
- An ECG monitor
- A CPR board (if required)
- Suction apparatus(electrical and/or alternative) plus range of soft and hard suction catheters
- Bag-mask manual ventilators in an appropriate number to suit the size of the facility
- Range of endotracheal tubes and 2 laryngoscopes, with a range of straight and curved blades, spare batteries, spare globes where applicable
- Introducer /stylet for endotracheal intubation
- Syringe to inflate ETT cuff
- Oropharyngeal tubes
- Equipment to perform an emergency crico-thyroidotomy - (needle and surgical)
- Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- Drugs for cardiac arrest, coma, fits and states of shock (including paediatric doses)
- Plasma expanders
- Pulse oximeter.

24.2.3 Criteria

24.2.3.1 Resuscitation equipment is available in accordance with the

policies of the organisation.

Critical criterion

Must include at least the items mentioned in the Intent statement and according to national requirements.

Resuscitation equipment must be available in the ward/unit and must be checked in accordance with the organisation's resuscitation policy. Checking must include expiry dates on medications and consumables such as airways and endotracheal tubes. Recorded evidence of this checking is required.

Linked criterion:
30.2.1.2

24.2.3.2 Recommended appliances are available for specialised resuscitations.

There should be devices for
- the stabilisation of the spine in adults and children.
- the stabilisation of long bone fractures.
- limb traction.
- pelvic compression.
- preventing hypothermia and for the active warming of patients.
Staff are trained in the use of specialised resuscitation equipment/devices.

Stabilisation of the spine is an essential initial step in the management of the poly-trauma patient. A range of sizes of hard cervical collars, stabilising head blocks plus padded spinal boards must be available. Where possible, these should duplicate those used by the Emergency Medical Services (EMS) so that they can be exchanged without compromising the patient whose spine has been properly stabilised by pre-hospital care providers.

24.2.3.3 Diagnostic and vital sign monitoring equipment is available as per organisational policy.

Basic vital sign measurement, ECG (where appropriate), Dynamaps, peak flow meters, etc.

Diagnostic "point of care" or "bedside" tests are performed within the emergency unit by non-laboratory staff and give rapid results. They are particularly important where laboratory facilities are not available on the premises; transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the emergency unit. Personnel are trained in the use of diagnostic equipment and quality controls are in place for all diagnostic equipment.

The following are required as a minimum. Equipment for:
- *determination of blood glucose levels*
- *finger prick haemoglobin or haematocrit testing*
- *urine testing*

- *Falciparum malaria testing (in areas where malaria is endemic, or where tourists are frequently seen)*
- *blood gas analysis (this should include lactate measurements if required by organisation policy)*

24.2.4 There is a rest area for personnel in close proximity to the clinical areas.

Standard Intent

Rest areas for personnel are adequately equipped to allow personnel to remain in the vicinity of the unit at all times. The type of facilities provided will vary between units and will depend on the length of shifts undertaken and access to other refreshment facilities.

24.2.4 Criteria

24.2.4.1 There is an adequately equipped kitchen, with at least a kettle, toaster and microwave.

If there is no kitchen in the staff rest area, but in close proximity to the department it is considered compliant. The same applies to criteria 2 and 3 in this standard.

24.2.4.2 There are rest room facilities for staff including a changing area, staff toilet and hand-washing facilities.

24.2.4.3 Where staff undertake 24 hour shifts, there are sleeping and shower facilities.

24.2.4.4 The staff rest area is equipped with a telephone or intercom system.

24.3 Visitors Control

24.3.1 *A system of visitors control is maintained to ensure the safety of patients and staff.*

Standard Intent

Controlling visitors' access to the unit is important, not only as a security precaution, but because anxious relatives in clinical areas can impede delivery of services. Additionally, community emergencies, VIP admissions and other newsworthy events may lead to invasion by the media. Policies should be available to guide all staff, but clerical and security staff are particularly important in implementing visitors control.

24.3.1 Criteria

24.3.1.1 The organisation's policy on visitors to the emergency unit is implemented.

Root criterion

Linked criterion:

24.15.1.3

24.3.1.2 There is a system to inform patients and family of the visitors' policy.

24.3.1.3 Areas, where access is denied to persons other than staff members, are clearly marked.

24.3.1.4 The discretionary powers of the staff in charge of the service relating to visitors under special circumstances are documented.

24.3.1.5 Policies regarding media invasion are implemented to guide clinical and security staff.

24.4 Patient Registers

24.4.1 *Patient registers are kept and comply with national requirements and/or organisational policy.*

Standard Intent

Organisations may be required by law and regulation to maintain registers of patients attending the emergency unit and patients receiving radiological investigations. Attendance registers should include mode of arrival, time of arrival, name, date, treatment administered and information on final disposition (admission, discharge, death or transfer).

24.4.1 Criteria

24.4.1.1 A register is kept of patients attending the emergency unit.

Root criterion

24.4.1.2 The register contains at least the patient's name, patient specific identification number, age, gender, date and time of admission, treatment, procedures, discharge, referral or death.

Critical criterion
Linked criterion:
4.2.2.1

24.4.1.3 The information in the register is used to monitor waiting periods from time of arrival to time of assessment.

Linked criterion:
24.12.1.2

24.5 Clinical Practice Guidelines

24.5.1 Clinical practice guidelines are used to guide patient care and reduce unwanted variation.

Standard Intent

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these will form the basis for structured clinical audits. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and organisational resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

24.5.1 Criteria

24.5.1.1 Clinical practice guidelines, relevant to the patients and services of the organisation, are available to guide patient care processes.

Guidelines/protocols "relevant to the patients and services" are assessed in each department according to the disease profiles of the patients admitted. Doctors and nurses follow National Clinical Practice Guidelines.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

In the absence of guidelines, this criterion will be scored NC.

Linked criterion:
1.3.2.1

24.5.1.2 Clinical practice guidelines include protocols for time critical states.

Time critical states are considered to be those where initial treatment takes place concurrently with assessment and where time spent telephoning for advice will almost certainly affect patient outcome negatively. It is difficult to provide a complete list and there is a large "grey area". Specialised emergency centres, e.g. trauma units or paediatric emergency centres may be exempted from some elements of this list. For general emergency centres, clinical guidelines for the management of time critical states should include at least the following:

1. *Chest pain (including acute MI)*
2. *Acute stroke*
3. *Airway obstruction*
4. *Respiratory arrest and respiratory failure*
5. *Head injury with GCS<12*
6. *Evaluation and resuscitation of the poly-trauma patient*
7. *Suspected ruptured major aneurysm*
8. *Control of major haemorrhage.*
9. *Cardiac arrest*
10. *Arrhythmias resulting in hypotension*
11. *Status epilepticus*
12. *Anaphylactic shock*
15. *Hypoglycemia*
16. *The unconscious patient*

24.5.1.3 The implementation of guidelines is monitored as part of a structured clinical audit.

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Sometimes such evidence exists for nursing practices only, in which case this will be scored PC.

Linked criteria:
8.2.1.4
24.12.1.2

24.5.1.4 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

24.6 Assessment of Patients

24.6.1 The organisation has a formal triage process, which uses written guidelines to determine urgency.

Standard Intent

This standard refers to initial screening/triage by either a medical practitioner or registered nurse. In urgent cases, initial management will take place simultaneously with assessment. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

It is essential that triage assessments be properly documented and legible and that they can be easily retrieved from the patient's record.

The triage assessment should take place within time frames established by the professional societies or the health organisation for the identification of patients with immediate needs e.g.

Red Patients:	Immediate
Orange Patients:	Less than 20 minutes
Yellow Patients:	Less than 60 minutes
Green Patients:	Less than 240 minutes

24.6.1 Criteria

Compliance of the following criteria will be verified during the ***patient record audit.***

24.6.1.1 Clinical records of emergency patients include the time of arrival.

24.6.1.2 The triage category for each patient is recorded.

Linked criteria:
24.1.3.2.
24.6.2.1

24.6.1.3 Clinical records of emergency patients include time of referral to medical practitioner.

24.6.1.4 Waiting times from triage categorisation to initial assessment are monitored.

Critical criterion
Linked criterion:
24.12.1.2

24.6.2 All patients cared for by the organisation have their health needs identified through an established assessment process.

Standard Intent

When a patient enters the Emergency Unit, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided. Assessments must be completed with due regard to privacy, this is particularly important when the patient is a victim of social or sexual violence.

The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations.

The health organisation determines the time frame for completing assessments.. When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation.

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process is modified in accordance with local custom. The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs

so that care and treatment can begin.

When the medical assessment was conducted outside the organisation, a legible copy of the findings is placed in the patient's record. Any significant changes in the patient's condition since this assessment are recorded.

24.6.2 Criteria

24.6.2.1 The organisation implements policies and procedures for assessing patients on admission and during on-going care

Root criterion

A policy defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during patient assessments. The provision of specifically designed assessment forms for each discipline represented is accepted as evidence of the implementation of such a policy.

Where the information relevant to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.

Time frames for the assessment of patients need to be established for each discipline, e.g. there should be an indication of which cases are urgent/or not priority cases. It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment needs to be done or completed. These time frames need to be stated in the policy framework.

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

Linked criteria:
1.2.6.1
24.1.3.2
24.6.1.2

24.6.2.2 Only those individuals permitted by applicable laws and regulations or by registration and appropriate training/experience perform the assessments.

Compliance will be verified during the ***patient record audit,*** *which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of notes made in the patient record by the doctor or relevant clinical personnel other than nurses will affect the outcome of the audit process.*

Linked criteria:
24.1.1.2, 24.1.2.5

24.6.2.3 The scope and content of assessment by each discipline is defined.

It is accepted that the scope and content of assessment for each discipline is defined if the organisation uses standardised clinical assessment forms for each discipline.
These forms should include at least

- *history*

- *physical examination*
- *vital signs*
- *provisional diagnosis*
- *diagnostic procedures*
- *treatment planning*

The absence of medical notes or notes by relevant clinical personnel, other than nurses, in the patient record will affect the outcome of the audit process.

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

24.6.2.4 Assessment findings are documented in the patient's clinical record and are readily available to those responsible for the patient's care.

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

Linked criterion:
24.1.2.2

24.7 Diagnostic Services

24.7.1 Diagnostic imaging services are available to meet patient needs.

Standard Intent

The organisation leaders ensure that appropriate diagnostic imaging facilities are available, that there are radiation safety programmes in place, and that individuals with adequate training, skills, orientation and experience are available to undertake X-ray procedures and interpret the results.

The diagnostic imaging service allows for immediate decision-making by practitioners through the provision of emergency services and the provision of emergency reports as necessary.

24.7.1 Criteria

24.7.1.1 Adequate and convenient diagnostic imaging services are available at all times.

It is important to note that this criterion addresses a number of issues.

With "adequate" one should take into consideration the level of service that is required e.g. does the Tertiary hospital provide a CAT scan, is there a Radiologist, etc.
The service should meet the needs of the population that it serves e.g. if the service is only available 2 or 3 days per week, but the need is there for a daily service, then this would warrant a PC score.

If equipment is broken or supplies are lacking, or staff are inadequate and the full scope of service (as required) cannot be rendered then the criterion should be scored down.

"Convenient" refers to the patient's experience and it should be considered that sometimes patients are referred "unnecessarily" somewhere else because of staff shortage, broken equipment, lack of supplies, etc. Or they have to be admitted on Saturday to wait for X-rays on the Monday, in which case this criterion will be scored down.

This would include the after-hour service. If there is no service available when required, this criterion will be scored PC.

Where SE 20 forms part of the assessment at the facility the identified linked criteria will apply.

This criterion should be scored similarly to criterion 20.1.1.1 in SE 20 Diagnostic Radiology and Imaging services.

Linked criteria:
1.2.2.3, 1.2.7.2

24.7.1.2 Established waiting times for diagnostic imaging studies to be done, according to triage status, are monitored.

Linked criterion:
24.12.1.2

24.7.1.3 Established waiting times for diagnostic images to be available are monitored.

Linked criterion
24.12.1.2

24.7.1.4 Where X-rays are initially read by emergency unit medical staff, there is a clearly defined system for review by appropriately qualified diagnostic imaging staff, when required.

Linked criterion:
20.1.3.4

24.7.2 *The emergency unit is adequately supported by clinical laboratory services.*

Standard Intent

Laboratory services, including those required for emergencies and after-hours, may be provided within the organisation, by agreement with another organisation, or both if outside sources are convenient for the patient to access. Whatever the arrangement, it is expected that laboratory services will be available 24/7 and should be on site or in close proximity to the emergency unit.

Point of care" or "bedside" tests are performed within the outpatient department by non-laboratory staff and give rapid results. They are particularly important where laboratory facilities are not available on the premises; transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the emergency unit. Determination of blood glucose, either finger-prick haemoglobin or

haematocrit testing; and urine testing are considered essential for an outpatient department. Centres in areas where malaria is endemic, or where tourists are frequently seen, should also have rapid, antigen based tests for the diagnosis of Falciparum malaria. Training and quality control are required for all point of care tests.

The majority of urgent clinical decisions can be made based on the results of point of care testing outlined above; however, emergency units require urgent laboratory services for the provision of specialised testing.

24.7.2 Criteria

24.7.2.1 Laboratory services are available at all times.

Critical criterion

Where SE 19 forms part of the assessment at the facility the identified linked criteria will apply.

This criterion should be scored similarly to criterion 19.1.1.1 in SE 19 Laboratory service.

Linked criteria:
1.2.3.3, 1.2.7.2

24.7.2.2 Established waiting times for laboratory tests to be done, according to triage status, are monitored.

Linked criterion
24.12.1.2

24.7.2.3 Established waiting times for laboratory results to be available are monitored.

Linked criterion
19.2.3.1
24.12.1.2

24.8 Patient Care

24.8.1 *Risks, benefits, potential complications, and care options are discussed with the patient and his or her family or with those who make decisions for the patient.*

Standard Intent

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent, for example verbally, by signing a consent form, or through some other mechanism. Patients and families understand who may, in addition to the patient, give consent. Designated staff is trained to inform patients and to obtain and document patient consent. These staff members clearly explain any proposed treatments or procedures

to the patient and, when appropriate, the family. Informed consent includes:

- an explanation of the risks and benefits of the planned procedure
- identification of potential complications
- consideration of the surgical and non surgical options available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed.

The organisation lists all those procedures that require written informed consent. Leaders document the processes for the obtaining of informed consent. The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledged full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

24.8.1 Criteria

24.8.1.1 There is a documented process for the obtaining of informed consent.

Root criterion

This section refers to all instances where patients give informed consent and compliance will be verified during the ***patient record audit****.*

If consent was not required for the patient records audited, this whole standard becomes NA.

An assessment is made of the provision of an organisational consent form and the completion of this form when indicated. This section will be scored NC if written consent is indicated but suitable forms are not used.

When 24.8.1.5 is scored PC or NC because the available consent form has not been completed correctly, this criterion will be scored PC, because the process has not been implemented.

Linked criteria:
5.6.1.1

24.8.1.2 Patients and their families or decision-makers receive adequate information to enable them to participate in care decisions.

24.8.1.3 Patients are informed about their condition, and the proposed treatment.

24.8.1.4 Patients know the identity of the medical practitioner or other practitioner responsible for their care.

This will be assessed during ***patient interviews.***

Linked criterion:
24.1.1.3

24.8.1.5 The information provided is recorded, with the record of the patient having provided written or verbal consent.

Critical criterion

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

If there is a correctly completed consent form (or a record of verbal consent) the implication is that the patient has been provided with the information as indicated in the relevant criteria above, this criterion and the relevant criteria above will be scored C.

Where the form is not completed in accordance with policy, this criterion will be scored PC or NC, depending on the average results of the record audit. The relevant criteria above will receive the same score.

Linked criterion:
24.8.1.1

24.8.2 *Invasive procedures and minor operations performed in the emergency centre are controlled by policy*

Standard Intent

Patients attending the emergency centre may require invasive procedures such as aspirations, biopsies, central venous cannulation or tube thoracostomy. Policies are required to define who should be doing these procedures, to ensure that they are performed based on clinical need and to control sterility of the procedure. Adverse events resulting from invasive procedures should be documented.

24.8.2 Criteria

24.8.2.1 Protocols address appropriate monitoring during and after the procedure.

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

24.8.2.2 Persons performing invasive procedures are appropriately trained.

24.8.2.3 The procedure and the name of the person performing the procedure are recorded in the patient's record.

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

24.8.2.4 Unsuccessful or complicated procedures are recorded.

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

24.8.3 Post procedure assessments are documented.

Standard Intent

A patient's post surgical care is related to the findings and the surgical procedure. The surgical report is available within a time frame needed to provide post-surgical care to the patient.

Post-operative monitoring is appropriate to the patient's condition and the procedure performed.

Results of monitoring influence intra and post operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

24.8.3 Criteria

Compliance with the following criteria will be verified during the ***patient record audit.***

24.8.3.1 A post-operative diagnosis is documented.

24.8.3.2 The name of the medical practitioner and the names of other personnel as required by law are documented.

24.8.3.3 The patient's physiological status is monitored during the immediate post-surgery period.

Critical criterion
Linked criterion:
24.6.2.1

24.8.4 *The organisation implements processes to support the patient in managing pain.*

Standard Intent

While pain may be a part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain is respected and supported.

The organisation has processes to:

- identify patients with pain during initial assessment and re-assessment
- communicate with, and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs
- educate health service providersin pain assessment and management.

24.8.4 Criteria

24.8.4.1 Patients in pain receive care according to pain management guidelines.

Critical criterion

There should be evidence that all clinical professionals dealing with the patient's pain management, have contributed to the patient's record. Monitoring of the effectiveness of the pain management must be recorded.

Evidence could include the documentation of pain using an individualised assessment form and pain scoring charts. Pain management continues with the prescription and administration of medication for pain as well as the follow-up assessment after treatment.

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

Linked criteria:
1.3.2.2
24.5.1.3

24.8.4.2 Patients and families are educated about pain and pain management.

Compliance will be verified during the ***patient record audit and patient interviews.***

24.8.4.3 The organisation has processes to educate health professionals in assessing and managing pain.

Linked criterion:
2.4.2.2

24.8.5 There is access to emergency blood and blood products in accordance with organisational policy.

Standard Intent

Major centres are required to have a blood bank on the premises. Other facilities should have emergency blood on site with access to banked blood within 1 hour. Regional and district centres should have at least 4 units of on-site blood, 2 units are considered minimum requirement for primary centres.

The type and amount of emergency blood and blood products to be kept on site will be determined by organisational policy. Emergency blood may, in some facilities, not be kept in the emergency care unit, but in another department. Arrangements for access at all times must form part of the organisational policy.

24.8.5 Criteria

24.8.5.1 Emergency blood is available at all times.

24.8.5.2 There is a designated refrigerator for emergency blood and blood products.

24.8.5.3 The temperature of the refrigerator is measured and recorded daily.

24.8.5.4 Emergency blood is subject to stock control, which includes the replacement of stock before its expiry date.

Critical criterion
Linked criterion:
1.2.2.2

24.9 Medication

24.9.1 Medication use in the organisation complies with applicable laws and regulations.

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.

Each organisation has a responsibility to identify those individuals with the requisite knowledge and experience, and who are permitted by law, registration or regulations to prescribe or order medications. In emergency situations, the organisation identifies any additional individuals permitted to prescribe or order medications. Requirements for documentation of medications ordered or prescribed and for using verbal medication orders are defined in policy.

24.9.1 Criteria

24.9.1.1 Policies and procedures that guide the safe prescribing, ordering, storage, dispensing and administration of medications are implemented.

Root criterion for all criteria in standards 24.9.1, 24.9.2 and 24.9.3

These policies need to be developed by all the role players i.e. medical practitioners, nurses and pharmacists.

national regulations will apply.

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

Linked criteria:
1.2.6.1
21.3.1.1
24.1.1.2

24.9.1.2 Policies and procedures that guide dispensing of medications in the unit are implemented.

Linked criterion:
21.4.1.2

24.9.1.3 The use of verbal/telephonic medication orders is documented.

The procedure to be followed must be clearly documented in line with current legislation and be implemented. Compliance will be verified during the ***patient record audit.***

Linked criteria:
7.2.2.1
21.3.1.1
24.9.2.3

24.9.1.4 Only those permitted by the organisation and by relevant laws and regulations prescribe medication.

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

Linked criteria:
21.2.1.1 to 21.2.1.5
24.1.1.2

24.9.1.5 Medications, including herbal and over the counter medications, brought into the organisation by the patient or the family are known to the patient's physician and are noted in the patient's record.

Implementation of the organisational policy is required. This includes traditional, over-the-counter and homeopathic medicines.

These should be represcribed on the prescription sheet if indicated.

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

24.9.2 Medications are safely administered.

Standard Intent

Only personnel who are suitably trained and experienced may administer medication to patients. The responsibility of these persons for medication administration is documented. The safe administration of medications requires a strict and comprehensive protocol.

The patient, doctor, nurse, and other care providers work together to monitor patients on medications. The purpose of monitoring is to evaluate the response to medication, adjust the dosage or type of medication when needed, and to evaluate the patient for adverse effects.

The organisation follows national requirements requirements for the reporting of adverse effects. Doctors, nurses, and pharmacists are expected to report reactions that are suspected to be adverse drug events, irrespective of whether the event is well recognised, potentially serious or clinically "insignificant".

There is a reporting process focused on the prevention of medication errors through understanding the types of errors that occur. Improvements in medication processes and staff training are used to prevent errors in the future. The pharmacy participates in such staff training.

24.9.2 Criteria

24.9.2.1 Only those permitted by the organisation and by relevant laws and regulations administer medications.

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

Linked criterion:
24.1.1.2

24.9.2.2 There is evidence that patients are identified before medications are administered.

Assess this in relation to the existing policy framework, including the use of patient ID bands.

Compliance is also to be confirmed while observing the medicine administration practices and during staff interviews.

Linked criterion:
7.2.1.3

24.9.2.3 Medications are checked against the original prescriptions and administered as prescribed.

Critical criterion

Compliance could be assessed by observing the giving of medication while visiting the clinical departments.

*During the **patient record audit** process, check for evidence of transcribing by nurses from the original prescription onto the medication administration sheet.*

Linked criteria:
1.2.6.6
21.3.1.1
24.9.1.3

24.9.2.4 Health professionals monitor medication effects on patients collaboratively.

***Patient record audits** should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the medical doctor.*

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional

information may be required. For example, plasma drug concentration may be used in the initiation and maintenance of certain medications.

Linked criterion:
21.1.2.1

24.9.2.5 Adverse Drug Reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the organisation.

*An **adverse drug reaction** (abbreviated **ADR**) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.*

*Compliance is verified during the **patient record audit.***

Documentation showing that the reaction was reported to the physician and the pharmacist must be evident.

Linked criteria:
7.1.1.7
21.6.1.1
24.15.1.2

24.9.2.6 Medication errors are reported through a process and within a time frame defined by the organisation.

A process needs to be in place for reporting and recording ~~of~~ medication errors. These include errors in relation to prescribing, dispensing and administering medication.

Linked criteria:
7.1.1.7
21.6.1.1
24.15.1.2

24.9.2.7 The medications prescribed for and administered to each patient are recorded.

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

24.9.2.8 Where prescribed medications are not available for administration, this is noted in the patient record.

24.9.3 Medications are stored in a safe and clean environment.

Standard Intent

Patient care units store medications in a clean and safe environment that complies with law, regulation and professional practice standards.

24.9.3 Criteria

24.9.3.1 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

All medication storage areas (trolleys, cupboards, rooms, refrigerator etc.) are examined for compliance.

An unlocked refrigerator will only be accepted if it is in a locked room with access limited to relevant staff members only.

An unlocked refrigerator in an unlocked room will be scored NC.

Linked criterion:
21.5.1.10

24.9.3.2 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

National laws and regulations or organisational policy will determine the nature of these medications.

24.9.3.3 Medications identified for special control (by law or organisational policy) are accurately accounted for.

Critical criterion
Compliance needs to be measured against the medicine control regulations.

Control measures generally include keeping medicine registers for these items.

Linked criterion:
21.5.1.11

24.9.3.4 Medications are securely and legibly labelled with relevant information as required by law and organisational policy.

Critical criterion

National regulations apply, but must include at least the following:
- *name of unit and/or name of patient and hospital number (if applicable)*
- *proprietary name/approved name or name of each active ingredient*
- *direction with regard to manner in which medicine must be used*
- *number of dose units in the container*
- *date of dispensing*
- *expiry date and batch number*
- *additional labels with warnings and storage instructions in accordance with organisational policy.*

Linked criterion:
21.4.1.4

24.9.3.5 Medications are stored in a clean environment.

This applies to all medicine storage areas in the hospital.

Linked criterion:
21.5.1.7

24.9.3.6 Medication is stored in accordance with manufacturer's instructions relating to temperature, light and humidity.

Note must be made of provision for medicines that should not be exposed to direct sunlight.

Where the ambient temperature (20-25˚C) in the cupboard/room cannot be maintained, there should be evidence that the environmental temperature is monitored and complies with the manufacturer's requirements for medicine storage.

Linked criterion:
21.5.1.9

24.9.3.7 A lockable refrigerator is available for those medications requiring storage at low temperatures.

There should be a refrigerator dedicated to the storage of medications only. Where this is not possible or practical, medications requiring refrigeration may be kept in a general refrigerator, in a sealed container to prevent contamination of the medication.

Linked criterion:
21.5.1.9

24.9.3.8 The temperature of the refrigerator is monitored and recorded.

Critical criterion

Documented evidence in the form of daily temperature recording and monitoring of the refrigerator/s needs to be available. The temperature must be maintained within a safe range according to manufacturer's specifications.

Linked criterion:
21.5.1.8

24.9.3.9 Expiry dates are checked (including those of emergency drugs), and drugs are replaced before expiry date.

Compliance needs to be measured against relevant laws and organisational policies.

Linked criteria:
21.2.1.7, 21.5.1.5

24.10 Patient and Family Education

24.10.1 Each patient receives relevant education, which is written in his or her record.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent, and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care, and continue care at home.

Variables like educational literacy, beliefs and limitations are taken into account. Each organisation decides on the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administration, they need to be educated. It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.

Community organisations that support health promotion and disease prevention education are identified and, when possible, on going relationships are established.

*Evidence of compliance will be obtained during the **patient record audit** and/or **patient interviews**.*

24.10.1 Criteria

24.10.1.1 Patients and families indicate that they have been informed about their diagnosis.

24.10.1.2 Patients indicate that they have been informed about the management of their condition.

Linked criteria:
4.2.3.2

24.13.1.1

24.10.1.3 Patients are educated about their diagnosis, relevant high health risks, e.g. safe use of medication and medical equipment, medicine and food interaction, diet and food interactions, defaulting on medication use, etc.

24.10.1.4 Patients and families indicate that they have been informed about any financial implications of care decisions.

Linked criterion:
4.2.3.3

24.11 Continuity of Care

24.11.1 The organisation designs and carries out processes to provide continuity of patient care services within the organisation and Coordination among health professionals.

Standard Intent

As patients move through a health organisation from admission to discharge or transfer, several departments and services and many different health service providersmay be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks.

24.11.1 Criteria

24.11.1.1 Established criteria or policies that determine the appropriateness of transfers within the organisation are implemented.

Root criterion

This refers to transfers between any departments within the health facility as well as admissions from the out patient or emergency units.

Please take note that a transfer to theatre is also regarded as an internal transfer.

Linked criterion:
1.3.2.1

24.11.1.2 Individuals responsible for the patient's care and its Coordination are identified for all phases.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

24.11.1.3 Continuity and coordination are evident throughout all phases of patient care.

*Compliance for this criterion and the following will be verified during the **patient record audit.***

24.11.1.4 The record of the patient accompanies the patient when transferred within the organisation.

24.11.2 *The organisation implements policies for the management of patients requiring short term observation and care.*

Standard Intent

Where emergency centres have short stay facilities, also known as admission/overnight or observation facilities, they should be controlled by policies, which address:

- which cases may appropriately be observed in the emergency centre rather than in in-patient facilities
- who is responsible for the patient
- timing of medical reassessment
- length of stay.

The facilities should be adequate for safe medical care and medical records should clearly state the parameters under observation and actions to be taken should these parameters change.

24.11.2 Criteria

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

Root criterion
Linked criterion:
4.2.2.5
24.6.2.1

24.11.2.2 The organisation has established appropriate time frames, which limit holding time in the emergency centre.

24.11.2.3 Patients under observation are reassessed at appropriate intervals, to determine their response to care and treatment, and this is documented in the record.

Critical criterion

*Compliance for this criterion and the following two criteria will be verified during the **patient record audit.***

Linked criterion:
24.11.2.1

24.11.2.4 Any significant changes in the patient's condition are noted in the patient's record and acted upon appropriately.

24.11.2.5 Any patient care meetings or other discussions are noted in the patient's record.

24.11.2.6 Holding times are monitored and audited.

Linked criterion: *24.12.1.2*

24.11.3 There is a process for admitting patients to in-patient facilities.

Standard Intent

The time that patients spend waiting for transfer to in-patient facilities should be minimised. Not only is this in the interest of patients' comfort and definitive management, but long holding times have a significant impact on the functioning of the emergency centre, using space, resources and nursing time. Admission delays are often the result of system failures and processes should be designed to deal with this. The emergency centre can become congested when there is a lack of in-patient beds. Certain strategies may be implemented to manage inpatient beds more efficiently, such as more frequent consultant ward rounds, and a so called "escalation policy" to address periods of particular overcrowding can be developed in advance with in-patient personnel.

24.11.3 Criteria

24.11.3.1 There is a process, known to personnel, for admitting patients to the organisation.

Root criterion *Linked criterion:* *4.2.2.2*

24.11.3.2 The unit which accepts the patient for admission is noted in the patient record.

'

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

24.11.3.3 The time of transfer is recorded.

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

24.11.3.4 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.

Linked criterion: *4.2.2.6*

24.11.4 There is a process known to staff to appropriately refer patients for specialised consultation/investigations at other health facilities.

Standard Intent

In some cases, medical practitioners refer patients for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialized treatment that the referring organisation may be unable to provide. The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

24.11.4 Criteria

24.11.4.1 Policies and procedures that guide the movement of patients for referral to another organisation are implemented.

Root criterion

The organisation must clearly describe the referral process, especially where patients are sent to another facility for specialist consultation or special investigations and then return to the original facility.

Note that this criterion does not refer to the transfer of a patient to another organisation to take over the care of the patient.

Compliance for this criterion and the following will be verified during the ***patient record audit.***

Linked criterion:
1.2.5.4

24.11.4.2 A copy of the referral note is available in the patient record.

24.11.4.3 Follow-up care, based on the findings of investigations/consultations performed outside the organisation, are noted in the patient record.

24.11.5 There is a process to appropriately transfer patients to another organisation to meet their continuing needs.

Standard Intent

Transfer may be for specialised consultation at another health facility and/or treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

While emergency units are obliged to resuscitate and stabilise all who need it, the patient may require transfer to another facility, either to address their on-going needs more appropriately, or because of patient or family choice. or financial

concerns.

In a well organised system, the capabilities of individual organisations will be catalogued and coordinated, so that arrangements will already exist with units to which the facility frequently refers. When transfer criteria and processes are formally agreed in advance, patients are more likely to receive appropriate emergency care when their needs exceed the capabilities of the facility.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be a brief process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

Appropriate information should accompany the patient, including at least:

- The reason for transfer
- Any special conditions related to transfer
- The condition of the patient before transfer
- Any interventions provided by the referring organisation.

24.11.5 Criteria

24.11.5.1 There is a documented process for transferring patients to other organisations.

Root criterion
Linked criteria:
1.2.5.4
4.1.1.10
24.11.5.7

24.11.5.2 The transferring organisation determines that the receiving organisation can meet the patient's continuing care needs, and establishes arrangements to ensure continuity.

24.11.5.3 The process for transferring the patient considers transportation needs.

24.11.5.4 A policy that dictates that the responsible clinician communicates the level of required care to Emergency Medical (ambulance) services is implemented.

24.11.5.5 The process determines that patients are accompanied and monitored by an appropriately qualified person during transfer.

Linked criterion where the organisation operates its own ambulance service.
3.4.2.4

24.11.5.6 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions provided by the referring organisation.

*Compliance for this criterion and the following will be verified during the **patient record audit.***

24.11.5.7 A copy of the transfer summary is available in the patient record.

Critical criterion

*Compliance for this criterion and the following will be verified during the **patient record audit.***

Linked criterion:
24.11.5.1

24.11.5.8 The health organisation agreeing to receive the patient is noted in the patient's record.

24.11.6 There is an organised process to appropriately discharge patients who are being treated and released.

Standard Intent

The organisation begins to plan for the patients' continuing needs as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

The summary contains at least

- the diagnosis of main and significant illnesses
- the results of investigations that will influence further management
- all procedures performed
- the patient's condition at discharge
- discharge medications and follow-up arrangements.

24.11.6 Criteria

24.11.6.1 There is a documented process to appropriately discharge patients.

Root criterion
Linked criterion:
1.2.5.4

24.11.6.2 The organisation works with the family, health practitioners and agencies outside the organisation to ensure timely and appropriate discharge.

*Compliance for this criterion and the following will be verified through **patient record audits**.*

24.11.6.3 Patients and, as appropriate, their families are given understandable follow-up instructions and this is noted in the patient's record.

The follow-up instructions may be provided to the patient by the doctor or by the nurse, following instructions from the doctor.

The instructions should include medications, wound care, possible complications, return for follow up care, when and where to obtain urgent care, etc.

24.11.6.4 A discharge note, which includes at least items a) to g) in the intent statement, is written~~,~~ by the medical practitioner when each patient is discharged.

24.11.6.5 Each record contains a copy of the discharge summary.

24.12 Quality Improvement

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

Standard Intent

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

It is the responsibility of 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 for quality monitoring and improvement.

Quality monitoring could include:

a) patient assessment
b) resuscitation interventions
c) procedures carried out
d) the use of antibiotics and other medications and medication errors;
e) the use of sedation/local anaesthesia;
f) the use of blood and blood products;
g) waiting times
h) patient and family expectations and satisfaction.

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.

A once off project such as acquiring a specific item of equipment, will be scored NC. Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

24.12.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

24.12.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings or specialised investigative studies. An indicator, in this context, is a measure used to determine improvements in clinical care over time (see intent statement for examples).

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

Linked criteria:
8.2.1.1
24.1.3.8, 24.4.1.3, 24.6.1.4

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

24.12.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.
Where the documentation (patient record) audit is a hospital wide multidisciplinary process that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

24.13 Patient Rights

24.13.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

24.13.1 Criteria

24.13.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable.

Implementation the policies will be evaluated during the patient record audits and patient interviews as well as by observation
This applies to all the relevant criteria below.

Linked criteria:
5.1.1.3
24.10.1.2

24.13.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
4.1.1.6
5.2.1.1-3
6.1.2.1
24.2.1.2

24.13.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

24.14 Prevention and Control of Infection

24.14.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

24.14.1 Criteria

24.14.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

Root criterion

The department participates in, and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

24.14.1.2 Infection control processes include prevention of the spread of respiratory tract infections.

24.14.1.3 Infection control processes include prevention of the spread of urinary tract infections.

24.14.1.4 Infection control processes include prevention of the spread of infection through intravascular invasive devices.

24.14.1.5 Infection control processes include prevention of the spread of infection through surgical wounds.

24.15 Risk Management

24.15.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes. (Service Element 7).

24.15.1 Criteria

24.15.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial, and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

24.15.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.
Linked criteria:
7.1.1.7, 7.2.6.4
24.9.2.5 and 6

24.15.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

24.15.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

24.15.1.5 The organisation's policy on handling, storing, transporting and disposing of health waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.
Linked criterion:
7.7.1.1