Republic of Rwanda

Ministry of Health

Rwanda Hospital Accreditation Standards

Performance Assessment Toolkit

2nd Edition

October 2014

Contents

Acronyms

ACLS	:	Advance cardiac life support
ARV	:	Antiretroviral
BLS	:	Basic life support
CBHI	:	Community-based health insurance
CPG	:	Clinical practice guideline
CPR	:	Cardiopulmonary resuscitation
DHIS-2	:	District Health Information System-2
ED	:	Emergency department
EIDSR	:	Electronic Integrated Disease Surveillance and Response
HIV	:	Human immunodeficiency virus
HMIS	:	Health management information system
ICU	:	Intensive care unit
IPC	:	Infection prevention and control
IHSSP	:	Integrated Health Systems Strengthening Project
JCI	:	Joint Commission International
M&E	:	Monitoring and evaluation
MoH	:	Ministry of Health
MSDS	:	Material safety data sheets

MSH	:	Management Sciences for Health, Inc.
NICU	:	Neonatal intensive care unit
PALS	:	Pediatric advanced life support
PBF	:	Performance-based financing
PCV	:	Pellet control of vaccine
PDSA	:	Plan-Do-Study-Act
PHECS	:	Pre-hospital Emergency Care Service
PMNCH	:	Partnership for Maternal, Newborn and Child Health
PPE	:	Personal protective equipment
RBC	:	Rwanda Biomedical Centre
QI	:	Quality improvement
SBAR	:	Situation, Background, Assessment, Recommendation
STI	:	Sexually transmitted infection
TB	:	Tuberculosis
TRAC	:	Treatment Research AIDS Center
USAID	:	United States Agency for International Development
WHO	:	World Health Organization

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Section 1

Guidance on Using the Toolkit

Purpose

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

How to use the toolkit

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

Who conducts the assessment?

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

Part of the learning process occurs through this participation. If one person tries to complete the assessment alone the process becomes an audit rather than a learning opportunity for the team. Performing the assessment together increases understanding of the services and fosters team spirit and, ultimately, ownership of the findings. When assignments of team members are being made it is important to identify individuals who have knowledge of the specific aspect of the service which they will assess. For instance, various members could review the availability

of supplies, whereas professional staff would be needed to evaluate the competence of staff in providing care and performing procedures. A community member may be requested to conduct interviews with patients who have used the services.

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

How is the toolkit organized?

The toolkit is organized into two sections. Section 1 describes the setup of the toolkit and provides guidance on how to use it. Section 2 is the quality assessment tool that is to be used in assessing the quality of services.

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

The assessment tool is outlined as follows:

- The five Risk Areas that are the major domains toward which risk-reduction strategies are directed.
- The Standards that represent the risk-reduction strategies for that domain. Standard numbers highlighted in grey are considered “critical”.
- The Levels of Effort that represent progressive achievement in reaching the expectations found in a Standard.
    - At Level 1, the policies, procedures, protocols and plans have been developed and communicated that describe the expected quality of care/services to be provided.
    - At Level 2, the processes (described in the policies, procedures, protocols, and plans) are implemented in a consistent way.
    - At Level 3, there are data to confirm successful risk-reduction strategies and continued improvement.
- The Performance Findings provide the team concrete elements to determine whether the standard is met. Four levels of findings are listed for each Level of Effort (0, 1, 2, and 3).

- The Overall Score is created by multiplying the weight (Level of Effort) of the element with the progress (Performance Findings) toward meeting the standard. For example, if the Level of Effort is "1" and the Performance Finding is scored "3", the overall score is 1 x 3 = 3. An Excel spreadsheet is available to assist with these calculations.

It is recommended that the team assess all the Standards and associated Levels of Effort initially to provide a baseline for future progress toward meeting the standards. For easy reference, the five Risk Areas are outlined in Table 1 with the associated standards. The highlighted standards have been identified as "critical" to providing safe, quality care. Standards that have been added in the 2nd Edition are noted as "NEW".

Table 1: Overview of Risk Areas and Standards (Standards highlighted are "critical")

Risk Area►	1	2	3	4	5
Standards	**Leadership Process and Accountability**	**Competent and Capable Workforce**	**Safe Environment for Staff and Patients**	**Clinical Care of Patients**	**Improvement of Quality and Safety**
1	Leadership responsibilities and accountabilities identified	Personnel files available, complete, up-to-date	Regular inspection of environmental safety	Correct patient identification	Quality and patient safety program
2	Strategic and operational planning	Credentials of physicians	Management of hazardous materials	Informed consent	Effective customer care program
3	Management of health information	Credentials of nurses and midwives	Fire safety program	Medical assessments complete and timely	Patient satisfaction monitored
4	Mentorship and oversight of healthcare facilities in catchment area (NEW)	Credentials of allied health professionals	Biomedical equipment safety	Nursing assessments complete and timely	Complaint and suggestion process

Risk Area►	1	2	3	4	5
Standards	**Leadership Process and Accountability**	**Competent and Capable Workforce**	**Safe Environment for Staff and Patients**	**Clinical Care of Patients**	**Improvement of Quality and Safety**
5	Financial management	Physician staff privileging	Stable safe water sources	Laboratory services available and reliable	Clinical outcomes monitoring
6	Efficient use of resources	Orientation to hospital and jobs	Stable electricity sources	Diagnostic imaging services available, safe, and reliable	Incident reporting system
7	Leadership for quality and safety	Staff members are competent (NEW)	Coordination of infection prevention and control program	Written plans for care	Staff demonstrate how to improve quality
8	Quality requirements in contract management	Sufficient staff to meet patient needs	Reduction of health care-associated infections (hand hygiene)	Clinical protocols available and used	Communicating quality and safety information to staff
9	Integration of quality, safety and risk management	Oversight of students/ trainees	Effective sterilization processes (NEW)	Protocols for managing high-risk patients/ procedures	Staff satisfaction monitored
10	Compliance with national laws and regulations	Training in resuscitative techniques	Effective laundry and linen services (NEW)	Complete maternal health care	
11	Commitment to patient and family rights	Staff performance management	Reduction of health care-associated infections	Complete child health care	

Risk Area►	1	2	3	4	5
Standards	**Leadership Process and Accountability**	**Competent and Capable Workforce**	**Safe Environment for Staff and Patients**	**Clinical Care of Patients**	**Improvement of Quality and Safety**
12	Patient access to services	Staff health and safety program	Barrier techniques are available and used (protective personal equipment)	Comprehensive HIV prevention and care (NEW)	
13	Efficient admission and registration processes		Proper disposal of sharps and needles	Comprehensive tuberculosis (TB) prevention and care (NEW)	
14	Effective inventory management		Proper disposal of infectious medical waste	Anesthesia and sedation used appropriately	
15	Effective medical record management		Prevention, control and monitoring of communicable diseases	Surgical services appropriate to patient needs	
16	Oversight of human subject research			Effective emergency triage	
17				Essential emergency equipment and supplies	

Risk Area►	1	2	3	4	5
Standards	**Leadership Process and Accountability**	**Competent and Capable Workforce**	**Safe Environment for Staff and Patients**	**Clinical Care of Patients**	**Improvement of Quality and Safety**
18				Ambulance service equipped	
19				Safe medication use	
20				Patients educated to participate in their care	
21				Communication among those caring for patients	
22				Referral/Transfer information is communicated	
23				Complete and thorough clinical documentation	

What methods can be used to conduct the assessment?

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

1. **Observation**

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

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

2. **Formal and informal interviews**

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

3. **Inventory**

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

4. **Review of documents**

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

What should be done with the Performance Findings?

The Performance Findings should be communicated and acted on.

- **Communicating the findings**

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

  a) Who needs the information;

  b) What information is needed;

  c) How the information will be delivered, e.g. in a meeting, memorandum or workshop;

  d) Who will convey the information / feed it back; and

  e) When the information will be given.

- **Taking action**

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

How often should an assessment be done?

Assessment is best conducted as a systematic process on a regular basis. During the initial stages the team will be measuring progress toward the goals twice a year. When most of the standards have been met (achieve level 3) the assessment may be done annually so as to ensure that they are being maintained.

Major Changes in the Second Edition

The standards and assessment tool were implemented over the course of one year in five hospitals. In March 2014, a task force of key stakeholders and users was convened to share experiences with the standards and make revisions. In addition, the Ministry requested that the performance-based financial assessment and accreditation assessment be integrated into “one assessment-one tool”. As a result, the following major changes were made in the standards and assessment tool.

New Standards

1. Mentorship and oversight of healthcare facilities in catchment area
2. Staff members are competent;
3. Effective sterilization processes;
4. Effective laundry and linen services;
5. Comprehensive HIV prevention and care;
6. Comprehensive tuberculosis prevention and care.

Deleted Standard

Collaboration and cooperation as all levels (covered in other standards)

Standards Moved

1. Communication among those caring for the patient was moved from Risk Area #2 to Risk Area #4;
2. Sufficient staff to meet patient needs was moved from Risk Area #1 to Risk Area #2.

Critical Standards

No longer critical:

1. Management of health information;
2. Management of hazardous waste;
3. Coordination of infection prevention and control program;
4. Proper disposal of sharps and needles.

Additional critical:

1. Credentialing of physicians, nurses and allied health professionals;
2. Staff health and safety program;
3. Fire safety program;
4. Stable safe water sources;
5. Stable electricity sources;
6. Effective sterilization processes.

Section 2

Rwanda Hospital Accreditation Standards

Performance Assessment Tool

Date:

Name of facility: _____

Location: (town, district/province) _____

Name(s) of assessor(s) _____

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

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

Risk Area #1: LEADERSHIP PROCESS AND ACCOUNTABILITY

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

STANDARD #1: Leadership responsibilities and accountabilities identified

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There are written, current documents that identify accountable leaders by name, position, and responsibilities.	0. There are no documents that describe the organization's current leadership structure. 1. A current organizational chart lists all leadership positions. 2. The current names of persons who are in the positions are listed on the chart and/or observed to be posted on office doors. 3. A document in the administrative manual describes the overall responsibilities of each of the leaders' and managers' positions.					
Level 2. The leaders and managers are carrying out their responsibilities according to their job descriptions.	0. Job descriptions are not available for the majority of the leadership positions. 1. A job description outlines the roles and responsibilities of the majority of the hospital leadership. 2. Current job descriptions are written for each hospital leader and manager. 3. Management meeting minutes (management and department) show evidence that they are carrying out their roles and responsibilities.					
Level 3. The performance of the leaders and managers is evaluated and measures have been taken to continuously improve the results of their efforts.	0. Personnel files are not kept for all members of the hospital leadership. 1. Personnel files are kept for all hospital leaders and managers. 2. The personnel files contain quarterly performance-based finance assessments and an annual performance evaluation that was conducted within the past 12 months. 3. The evaluations include objectives, goals or an action plan for improving performance.					

STANDARD #2: Strategic and operational planning

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. The leadership has developed a strategic plan that supports long-term goals based on the mission, vision and values of the hospital and accurate data.	0. Information regarding community needs is not available. 1. Community needs are assessed through collection of service data that describes: a. Geographic catchment area; b. Population demographics; c. Types of services and patient volumes; d. Disease prevalence; e. Main occupations and businesses; f. Schools; g. Other health facilities. 2. A strategic plan (long-term goals) is present that has been approved within the past 36 months. 3. The following documents are present in the administrative manual: • Mission, vision and values specific to the organization; • Description of hospital; • Organizational chart; • Scope and organization of services; • Communication and collaboration: a. Standing (regular) meetings; b. Committees. • General hospital policies: a. Admission b. Referrals c. Discharge d. Staff code of conduct e. Staff identification f. Visitors g. Smoking h. Community participation in hospital planning and outreach					

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 2. The mission, vision, values and plans are communicated to staff and implemented.	0. There is no evidence that the mission, vision, values or plans have been communicated to all staff. 1. Leaders describe how the mission, vision, values and plans are communicated to staff members. 2. An operational plan (short-term goals) is present to implement the strategic goals. 3. The plan includes maintenance of equipment and the infrastructure.					
Level 3. Progress in achieving the goals and objectives is measured and reviewed in management meetings on at least a quarterly basis.	0. There are no or few minutes that show discussions regarding the measures of progress. 1. Management meeting minutes include discussions of the goals and objectives quarterly. 2. Data is gathered to measure progress in meeting goals / objectives. 3. Management meeting minutes reflect analysis of the data and actions planned to further the achievement of the goals/objectives;					

STANDARD #3: Management of health information

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies and procedures are in place to guide management of health information.	0. There are no policies and procedures regarding management of health information. 1. There are policies and procedures for management of health information that include at least; a. Who is responsible for collecting data; b. How data is collected and compiled; c. Data quality control; d. Data reporting/ dissemination, analysis, access, use and confidentiality; e. Management of policies and procedures (maintenance). 2. Staff involved in management of health information is trained and has the required skills. 3. Data collection tools are available and data collectors demonstrate that they know how to use them.					
Level 2. The management of the health information system is carried out according to policies and procedures.	0. Management of health information is not consistently done according to policies and procedures. 1. Management of health information is consistent with the existing policies and procedures. 2. Complete hospital DHIS-2 data is provided to the Ministry of Health monthly (review past six months). 3. Required hospital TRAC Net data is transmitted before the 5th day of every month to the MOH (Review the electronic file provided by RBC/ HIV Division).					
Level 3. The leaders use the health data to make sound decisions.	0. The data is not available or there is no evidence that it is used consistently to make management decisions. 1. Health data is available and there is evidence that it is used consistently to make management decisions, e.g. meeting minutes. 2. Data are reviewed for data quality control (e.g. extreme values, missing data) and documented; the data manager and/or M&E officer communicate the results to the departments. 3. Monthly reports analyzing hospital data contain: a. Analysis using graphs with trend lines; b. Minutes of monthly meetings with heads of departments in which feedback is provided on the results; c. Monthly reports of analysis of HMIS data (Refer to checklist).					

STANDARD #4: Mentorship and oversight of healthcare facilities in catchment area

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies and procedures describe the roles and responsibilities of hospital leadership in mentoring and providing oversight to the associated healthcare facilities and implementation plans exist.	0. There are no policies and procedures that describe the hospital leaderships' roles and responsibilities in mentoring and providing oversight to the healthcare facilities. 1. A current policy and procedure is available that describes the hospital leaderships' roles and responsibilities in mentoring and providing oversight to the health care facilities within the catchment area, including: a. Technical support provided for managing complicated conditions; b. Antiretroviral (ARV)consultations; c. Financial overview of use of funds in accordance with stated objectives; d. Analysis of community indicators and reports. 2. There is a quarterly Coordination, Oversight and Mentoring Plan, which includes: a. Objectives; b. Strategies; c. Activities; d. Timeframe; e. Responsibility. 3. A transmission letter indicates that the quarterly plan has been received by the concerned healthcare facility.					
Level 2. The hospital leadership provides monthly mentoring and oversight of each of the associated health care centers.	0. The hospital leadership is not consistently providing monthly mentoring and oversight of the healthcare facilities. 1. Meeting minutes show that hospital leadership meets with the facility management on a monthly basis. 2. Patient registers show that the hospital physician has consulted with patients on a monthly basis, which includes a summary report. 3. The patient records reviewed at the health center indicate that the hospital physician consulted with the patients.					
Level 3. The effectiveness of the mentorship/ oversight program is evaluated and measures have been taken to continuously improve the results of their efforts.	0. A quality assessment has not been conducted on a monthly basis and/or is not accurate of complete. 1. The hospital leadership verifies that an accurate and complete monthly quality assessment has been conducted. 2. The hospital leadership conducts an accurate and complete quarterly quality assessment of each associated healthcare facility 3. The hospital leadership assesses the effectiveness of the program annually in collaboration with the health care centers.					

STANDARD #5: Financial management

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies and procedures are in place to guide financial management and resources are budgeted to achieve the strategic and operational plans.	0. No policies and procedures are in place regarding financial management and/or hospital managers are not involved in financial planning. 1. Policies and procedures for financial management include at least: a. Authorization and approval of expenditures; b. Accounting controls in place; c. Inventories and assets management; d. Financial reporting; e. Control of financial documents; f. Internal and external audit processes; g. Management oversight on financial management. 2. Hospital managers are trained in required financial management skills. 3. Consolidated budgets are developed and aligned with the hospital annual plan that includes a budget line for maintenance of equipment and the infrastructure.					
Level 2. Financial management policies and procedures are effectively implemented.	0. Cash controls and reconciliation of accounts are not consistently carried out. 1. Cash controls and reconciliation of accounts is completed according to financial management policies and procedures. 2. Documentation reveals that invoicing of services is done according to approved tariffs, which are displayed in public areas within the hospital (e.g. reception, paying posts). 3. Financial reporting to relevant authorities including community based health insurance (CBHI) bills is timely and accurate (Discrepancy between the amount billed by the hospital and the amount after verification by CBHI must not exceed 1% after the audit.)					
Level 3.Managers monitor the management of finances.	0. A consistent monthly process for monitoring finances is not evident. 1. Reports/minutes show that previous financial internal and external audit recommendations are implemented. 2. Interviewed managers are able to describe how they ensure that proper financial internal and external control procedures are being followed and previous audit recommendations are implemented. 3. Reports/minutes show that managers review hospital budget implementation and adjust accordingly.					

STANDARD #6: Efficient use of resources

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Staff members have knowledge and skills regarding resource management.	0. Staff members are not trained in resource management. 1. Staff training has occurred in a few departments within the past year, on topics such as: • Providing patient services in the most appropriate care setting (use of specialty units, appropriate admissions and discharges, length of stay); • Reducing variations in patient care delivery (use of protocols); • Reducing system inefficiencies and waste. 2. Staff training is targeted to resource management issues specific to the department. 3. Staff interviewed is aware of actions taken in their department to improve resource management.					
Level 2. Actions have been taken to improve resource management.	0. No actions have been taken based on the training. 1. Documents indicate that at least two departments have identified opportunities to improve resource management. 2. Plans have been made to improve use of resources (e.g. decrease rejected lab specimens, decrease x-ray retakes, decrease waste of drugs or supplies, or decrease inappropriate use of tests and procedures) 3. Meeting minutes indicate that the plans have been implemented.					
Level 3. Actions taken to improve effective resource management are measured.	0. Little or no data has been collected to improve use of resources and/or the data is incomplete or inaccurate. 1. Data have been collected that is complete and accurate for each of the planned improvements. 2. Data have been analyzed and interpreted using charts and graphs. 3. The plans for resource management are updated based on the results, e.g. by using PDSA methodology.					

STANDARD #7: Leadership for quality and patient safety

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. The quality and patient safety leaders within and outside the hospital are identified in the quality plan.	0. The quality plan does not include a description of the persons accountable for quality and safety. 1. The quality plan includes a description of the persons accountable for quality and safety. 2. The responsibility for quality and safety is included in the job descriptions of the leaders and managers. 3. The responsibility for quality and safety of the central and district health teams is included in the quality plan.					
Level 2. The leadership, including committee chairpersons, is trained in quality management.	0. Evidence of training in quality management was not located in leadership and committee chairpersons' personnel files or training records within past 12 months. 1. Training records show that quality training was provided for some leaders within the past 12 months. 2. Leaders demonstrate use of the knowledge to lead quality improvement (QI) activities within their departments (e.g., graphs, project description). 3. Leaders avail resources and ensure implementation of safety policies/procedures and plans.					
Level 3. The leaders set the priorities for quality improvement in the hospital at least annually and monitor progress toward meeting targets.	0. There are no priorities listed in the quality plan and/or evidence of leaders monitoring the progress toward meeting targets. 1. Management meeting minutes show that leaders have identified the priorities for improvement in the quality plan for the current year. 2. Priorities are identified within the past 12 months in the quality plan that includes the criteria for selection (e.g. high risk) and measures of success. 3. Leaders monitor the progress of achieving targets on a monthly basis as evidenced in the management meeting minutes.					

STANDARD #8: Quality requirements in contract management

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A policy and procedure describes the mechanism for management of contracts that includes negotiation and approval of all contracts.	0. A policy and procedure for managing contracts has not been written and/or quality requirements are not included. 1. A policy and procedure for management of contracts includes definition of quality requirements during the negotiation phase. 2. A policy and procedure for management of contracts describes the process for approving contracts, which includes the role of the hospital in the process. 3. Contracts are approved, signed and dated according to the policy and procedure.					
Level 2. Contracts include quality requirements.	0. Copies of the contract are not on file. 1. Copies of contracts are kept on file within the facility. 2. Contracts describe expectations regarding the quality of the services. 3. A review of contract files shows that the management of the process is carried out according to policies and procedures (e.g. PBF purchasing contracts.)					
Level 3. Contracts are renewed only when the quality requirements are met.	0. The files do not contain documentation regarding a review of the quality of contract services. 1. Information in the contract file includes communication with the contractor regarding quality. 2. Documentation in the file shows quality audit data, e.g. housekeeping checklists, results of patient satisfaction surveys. 3. A review of the quality of the contracted service has been documented within the past 12 months. (If quality requirements are not met, actions are taken and contracts may be terminated if issues are not resolved.)					

STANDARD #9: Integration of quality, safety and risk management

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. The integration and communication between the quality and safety committees and other risk management activities of the organization is described in the quality plan.	0. Coordination and communication between quality and safety committees and other risk management activities are not described in the administrative manual. 1. There is a description of communication/coordination between committees in the administrative manual or quality plan, e.g. diagram showing information flow. 2. The committee's terms of reference describes the types of information that are reported between committees and how collaboration occurs. 3. Meeting minutes show communication and collaboration occurred as planned.					
Level 2. Quality and safety committees are integrated and coordinated, and data collection and analysis processes are integrated when appropriate.	0. There is no evidence that committees/departments share data collection and analysis. 1. The committee structure shows that quality and safety committees report data to the same senior manager. 2. Quality and safety reports are reviewed and signed by a common senior manager. 3. Documentation indicates that joint analysis of adverse and sentinel events is done (Note: these types of incidents do occur and if none are reported within 12 months, this is not met.)					
Level 3. Improvements that are implemented have considered quality and safety implications.	0. Improvement efforts are carried out independently without consideration of the quality and safety implications. 1. Meeting minutes include staff involved with QI and safety. 2. Interviews with committee members indicate collaboration of quality and safety activities. 3. Documentation of improvements demonstrates consideration of quality and safety issues.					

STANDARD #10: Compliance with national laws and regulations

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Designated individuals are responsible for ensuring compliance with ministerial instructions, national laws and regulations.	0. A policy and procedure is not present regarding communicating ministerial instructions, laws and regulations. 1. A policy and procedure describes the process for communicating ministerial instructions, laws and regulations 2. There are documents that identify the ministerial instructions, laws and regulations for healthcare facilities, which are filed in an orderly fashion and easy to locate. 3. A leader has been identified who oversees communication and adherence to laws and regulations.					
Level 2. There is a mechanism for staying aware of the ministerial instructions, national laws and regulations that apply to the hospital and for reporting and responding to audit and inspection reports.	0. Leaders are not knowledgeable of the laws and regulations that apply to their areas. 1. When interviewed, leaders are knowledgeable of the laws and regulations that apply to their areas. 2. An external facility inspection and/or audit reports are present that are dated within the past 12 months. 3. There were no deficiencies or the facility report noted deficiencies and a corrective action plan is present. ***Note:*** *These are inspections/audits conducted by external groups, e.g. MoH, Public Service Commission (human resource policies) or fire brigade.*					
Level.3. The hospital leaders are informed when the organization does not comply with ministerial instructions, national laws and regulations and how compliance problems have been resolved.	0. The hospital leaders are unaware of whether the organization is in compliance with laws and regulations and/or there are observations that the organization is not in compliance. 1. When interviewed, leaders were able to describe methods used to ensure compliance with laws and regulations. 2. Audit data were available demonstrating compliance monitoring. 3. There are no problems identified during the facility tour in which laws were not followed. ***Note:*** *Any problem, such as hazardous wastes not managed according to law and regulation or lack of required fire safety equipment, would be scored "0".*					

STANDARD #11: Commitment to patient and family rights

Levels of Effort	Performance Findings	Score 0	1	2	3	Overall
Level 1. The organization has identified patients' and family rights and communicated them to staff.	0. No documents are present that describe patient and family rights. 1. A document is present that describes patient and family rights that includes at least: • Dignity and respect; • Privacy; • Confidentiality; • Safety and security; • Right to choice; • Right to information; • Right to complain; • Right to refuse treatment; • Right to pain management. 2. Policies and procedures are in place to identify patient and family cultural and spiritual beliefs that need to be considered when providing care or treatments. 3. Staff members are aware of the patient and family rights. ***Note:*** *The right to choices may include:* • *How individuals are addressed (name/title they prefer);* • *Their personal belongings;* • *Their clothing and self-care routines;* • *Food, drink and meals;* • *Activities, interests, privacy, visitors.*					
Level 2. Staff respect and protect the rights of patients and their families, including recognizing the cultural and spiritual sensitivities of patients/ service users and their communities.	0. Observations indicate that patient and family rights are not routinely respected e.g. lack of privacy or confidentiality. 1. Patients' and family rights are posted for public view. 2. Staff members are able to describe how they protect patient and family rights. 3. Patient and family rights are routinely respected:					
Level 3. The hospital asks patients about respect for their rights and uses the information to educate/ train staff and improve.	0. The patient satisfaction survey does not include questions about patients' and family rights. 1. The patient satisfaction survey includes questions regarding respecting patient and family rights (Note: This is not a question like "Does the staff respect your rights?" It would be questions like, "Was your privacy respected?".) 2. The survey results are documented and show the percentage of patients/families that feel that their rights have been respected. 3. Minutes or an action plan shows the analysis of the findings and actions taken (when indicated) to resolve the concerns expressed by patients and families.					

STANDARD #12: Patient access to services

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. The scope of services provided by the hospital is described, which is aligned with the service package, and based on the needs of the community.	0. The scope of services provided at the hospital is not described. 1. The scope of services provided at the hospital is described in the administrative manual that are aligned with the required service package. 2. The scope of services are consistent with the community needs identified. 3. The list of services provided at the hospital is observed to be posted for public view.					
Level 2. Barriers to access are investigated and actions taken to make improvements.	0. Barriers to access have not been identified. 1. Barriers to access have been identified and documented, including physical, mental, financial, and special needs patients. 2. Priorities for reducing barriers have been established. 3. Plans have been developed to address priority issues.					
Level 3. Data is used to inform decisions to improve access to services.	0. Measures have not been taken to make improvements. 1. Meeting minutes show that the plans to reduce barriers are being implemented. 2. Data are used to measure improvement of access to services, e.g. reduced wait times. 3. Data shows that access to services has been improved.					

STANDARD #13: Efficient admission and registration processes

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Services are well marked internally and externally. Policies and procedures for admission and registration processes are written, including admission and discharge criteria to specialty units (e.g. ICU, mental health).	0. Services are not well marked. 1. There is clear, visible internal signage that includes the names and directions for main hospital areas and services. 2. External signage provides guidance for the public to locate the hospital from the main roads and Y junctions to hospital. 3. Admission and registration policies and procedures are written: a. Inpatient and emergency admissions; b. Outpatient registration; c. Admission/discharge criteria for specialty units; d. Continuity of care tools in mental health (refer to the checklist).					
Level 2. An efficient process for admitting patients is in place and admission and discharge criteria are used to make decisions regarding the most appropriate patient placement.	0. Customer care is not consistently available to patients during the admission process. 1. Patients are observed to routinely have access to customer care during admission. 2. Staff interviewed in specialty units describes a daily collaborative process for evaluating patients' conditions and using the information to make patient placement decisions, e.g. transfer out of ICU, discharges home. 3. Pre-admission assessments are performed to determine the patient's fitness for procedures and ensure that adequate arrangements are made in preparation for hospitalization.					
Level 3. The efficiency of the admission process and the use of admission and discharge criteria for patient is monitored and measures are taken to improve the process.	1. A client flow analyses has not been conducted and/or not carried out effectively. 2. Client flow analyses are conducted to determine efficiency of admission/registration processes, e.g. reduce wait times. 3. Data are collected, such as number of outpatient visits, inpatient length of stays, and length of stay in particular units, e.g. ICU or ED, to monitor effectiveness of admission/discharge processes. 4. Plans are implemented and monitored to improve the efficiency of admission/discharge/ registration processes.					

STANDARD #14: Effective inventory management

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies and procedures to manage stocked supplies are in place in each department.	0. Policies and procedures are not in place to manage supplies and equipment in each department. 1. Policies and procedures are available for stock management in each department. 2. Each department has a list of required and existing supplies, equipment and instruments. 3. A staff member in each department is assigned to ensure adequate levels of supplies are available.					
Level 2. Staff members responsible for inventory management are trained to carry out systematic processes to manage inventories.	0. Inventory management is not consistently carried out. 1. Staff interviewed describes a systematic process for reordering supplies and replacing equipment and instruments, e.g. first expired-first out rules. 2. Records include maximum/minimum levels and accurate counting of inventory, using stock control cards or register with stock in and stock out. 3. Supplies and equipment are observed to be organized and neatly displayed.					
Level 3. Data are collected to determine the effectiveness of inventory management.	0. Data are not used to measure the effectiveness of inventory management. 1. Staff interviewed describes the use of quality improvement processes (e.g. 5-S) to standardize and maintain inventories. 2. Supply and equipment storage areas were observed to be organized. 3. Data are used to measure the effectiveness of the inventory management systems, e.g. monitoring stock outs.					

STANDARD #15: Effective medical record management

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A current policy and procedure manual describes the management of medical records.	0. A policy and procedure regarding identification of patients for the purpose of medical record management is not present. 1. The unique patient characteristics that are used to ensure patients have only one medical record is described in a policy, including at least: a. patient's full name b. date of birth (when known); another option may be the health insurance number. 2. Policies and procedures are written for at least the following: a. Completion of medical records prior to filing b. Filing, record retrieval and tracking systems c. Archiving and destruction of medical records d. Medical record confidentiality e. Verification process of required documents f. Master patient index 3. A central archival system is observed to be in place.					
Level 2. Each medical record contains sufficient information to identify the patient. Each patient has one medical record and all admissions are filed in the one folder. A process is carried out to verify that all required documentation is complete after discharge.	0. There is no master patient index or it is not complete. 1. A master patient index includes all patients' names and medical record numbers. 2. There is only one medical record per patient that is filed in the same folder. (Outpatient visits are documented in the same medical record as inpatient notes). 3. Identifying information is recorded on each medical record form (written, typed, stamped, or on a computer generated label) in the same location.					
Level 3. There is a central archival system that is well-organized such that medical records are easily located, the records are safe and secure.	0. The records are not well organized, secured or easily retrieved. 1. Records are observed to be stored in an orderly, accessible manner in a safe and secured location. 2. Staff interviewed describes an effective retrieval and tracking process. (Staff can retrieve patient records within 15minutes.) 3. Archival staff interviewed describes a process for verifying that all required documentation is complete within 15 days of patient discharge.					

STANDARD #16: Oversight of human subject research

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is a committee or other mechanism to provide oversight of all research involving human subjects.	0. There is no process for providing oversight of human research subject studies. 1. A committee exists that provides oversight of human research subject studies. 2. The committee has terms of reference. 3. Hospital leaders describe the process for approving human research subject studies. ***Note:*** *All hospitals are to meet at least Level I, even if they do not currently conduct human research. The committee may be ad hoc.*					
Level 2. There is verification of authorization and oversight that all research protects the rights and safety of subjects/patients.	0. The human research subject studies conducted at the hospital have not been reviewed. 1. Research studies involving human subjects have been reviewed and approved by the recognized body (e.g., National Ethics Committee) according to laws/regulations. 2. For patients participating in a research study, a signed patient consent form is obtained, signed by two witnesses, and kept in a research file. 3. The medical record indicates that the patient received a copy of the signed consent form ***Note:*** *If humans research subject studies are not conducted in this hospital, score as not applicable.*					
Level 3. There is a report to show that the research is carried out according to protocols in respect to patients' rights and to guide enhancements to the program of research oversight.	0. There is no data to show that the process for providing oversight of human research subject studies is effective. 1. Documentation in the patient's medical file indicates that the patient is participating in a research study, e.g. a signed consent form. 2. The process for providing human research study oversight is monitored. 3. Data is aggregated and used for improving program oversight.					

Risk Area #2: COMPETENT AND CAPABLE WORKFORCE

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

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

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. Policies describe the content that is to be included in the personnel file and job descriptions.	0. A policy describing the contents of personnel files is not written and/ or does not contain the required elements. 1. A current policy outlines the content of personnel files and includes: a. Current job description; b. Curriculum vitae; c. Copies of required credentials including degrees / diplomas, evidence of registration certificates and current license (if applicable); d. List of privileges (if applicable); e. Evidence of completion of resuscitation training (if applicable); f. Performance evaluation quarterly (PBF) and annually (MIFOTRA); g. Training certificates; h. Evidence of participation in orientation (new personnel only). 2. A current policy indicates that the job description contains at least: a. Education, training and experience required; b. Reporting relationship (who they report to); c. Roles and responsibilities; d. PBF contract (motivation); e. Job contract. 3. A policy describes the content of volunteer and contracted personnel files: a. Copy of contract; b. Qualifications (education, training, and experience); c. Current professional license (if indicated); d. Proof of orientation; e. Required health assessments/vaccinations. ***Note:*** • *Orientation records are only expected for personnel that have been hired within the past six months.* • *Other forms of documentation would be acceptable, e.g. computerized list of staff that participated in an activity with dates of the activity and the providers. This would include training activities and lists of vaccinations.*					

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 2. Personnel files are filed in a standardized order and contain all required elements as described in the policy.	0. One or more files did not contain evidence of a current license. 1. All of the personnel files reviewed had evidence of a current license (when required). 2. The majority of personnel, volunteer and contractor worker files contained the required items. 3. Personnel files were arranged in an organized standard format.					
Level 3. A process is in place to keep personnel files up-to-date.	0. There is no or an inconsistent process for maintaining the personnel files up-to-date. 1. A policy and procedure describes the process for maintaining personnel files up-to-date. 2. Performance-based finance (PBF) reviews, conducted within the past six months, are present in the personnel files. 3. The online Human Resource Information System is available and updated with a current list of quarterly payments of salary +PBF.					

STANDARD #2: Credentials of physicians

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A policy and procedure describes a uniform process for gathering and verifying physicians' credentials.	0. There is no policy and procedure listing the required physician credentials. 1. A current policy and procedure lists credentials required including registration and certification with medical council, licensure, education, and training and how physicians are appointed based on credentials. 2. A uniform process for gathering the credentials is described in the policy and procedure. 3. The policy and procedure describes conducting verification of credentials. *(**Note:** the primary source verification may be conducted by the medical council; however the policies and procedures need to indicate that this is the process.)*					
Level 2. The credentials are gathered and verified according to the policy and procedure.	0. A complete set of required credentials is not maintained for each physician. 1. All credentials required are copied by the hospital and maintained for each physician in their personnel files. 2. Appointments are not made until at least licensure/registration are verified. 3. When physician work responsibilities require specific qualifications (e.g. surgery, obstetrics), verification (by the medical council) of training in that specialty is documented in the personnel file. *(**Note**: Select files of physicians working in areas that require specific qualifications, e.g. surgery. Documentation needs to be in the file that the medical council has carried out the verification)*					
Level 3. Evidence shows that the credentialing process is effective.	0. There is no data that show that the verification process is carried out according to the policy and procedure. 1. A dated and signed document indicating that credentials verification has been done for each physician is present. 2. A document is present showing that the hospital verifies that the 3rd party medical council) implements the verification process described in the policy and procedure. 3. Audits are conducted to ensure that physician appointments are made according to hospital policy.					

STANDARD #3: Credentials for nurses and midwives

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A policy and procedure describes the process for gathering and verifying credentials and assigning nurses and midwives job responsibilities accordingly.	0. There is no nursing staff credentialing policy and procedure. 1. A current policy and procedure lists credentials required including registration and certification with the nursing society, licensure, education, training and competence 2. A current policy and procedure describes conducting verification of credentials through the professional nursing council. 3. A current policy and procedure describes how nurses and midwives are assigned job responsibilities based on their credentials and when extending their scope of services (task shifting). ***Note:*** *For file review, select nursing and midwives staff members (include the nursing director, emergency department, ICU, surgical, dialysis and others according the services provided). Identify in the job descriptions what is required for these positions, e.g. ICU staff should have training in critical care.)*					
Level 2. The credentials are gathered and verified according to the policy and procedure and nurses and midwives are assigned roles and responsibilities based on the credentials.	0. A complete set of required credentials is not maintained for each nurse and midwife. 1. All credentials required are copied by the hospital and maintained for each nurse and midwife in their personnel files. 2. Nurses and midwives that are extending their scope of services (task-shifting) have associated competency levels defined and assessed, which are documented in the majority of personnel files 3. Nurses do not provide direct patient care until at least licensure/registration are verified. *(**Note:** For file review, select nursing and midwives staff working in areas that require specific qualifications, e.g. ICU, ED, dialysis, in-charge, anesthesia tech, midwife)*					
Level 3. Evidence shows that the credentialing process is effective	0. There is no data that show that the verification process is carried out according to the policy and procedure. 1. A dated and signed document indicating that credentials verification has been done for each nurse is present. 2. A document is present showing that the hospital verifies that the 3rd party (nursing council) implements the verification process described in the policy and procedure. 3. Audits are conducted to ensure that nursing staff appointments are made according to hospital policy.					

STANDARD #4: Credentials of allied health professionals.

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A policy and procedure describes the process for gathering and verifying credentials of allied health staff and assigning staff job responsibilities accordingly.	0. There is no allied health staff credentialing and assignment policy and procedure. 1. A current policy and procedure lists credentials required including registration and certification with the allied health professional councils, licensure, education, training and competence. 2. A current policy and procedure describes conducting verification of credentials through the professional councils. 3. A current policy and procedure describes how the allied health staff credentials are used to assign job responsibilities and when extending their scope of services (task shifting).					
Level 2. The credentials are gathered and verified according to the policy and procedure and allied health professionals are assigned roles and responsibilities based on the credentials.	0. A complete set of required credentials is not maintained for each allied health professional. 1. All credentials required are copied by the hospital and maintained for each allied health professional in their personnel files. 2. Allied health professionals that are extending their scope of services (task-shifting) have associated competency levels defined and assessed, which are documented in the majority of personnel files. 3. Allied health professionals do not provide direct patient care until at least licensure/registration are verified. ***Note***: *For file review, select staff members including lab, radiology, physiotherapy and others according the services provided. Identify in the job descriptions what is required for these positions and determine whether the personnel files contain documentation that these qualifications are met.*					
Level 3. Evidence shows that the credentialing process is effective	0. There is no data that show that the verification process is carried out according to the policy and procedure. 1. A dated and signed document indicating that credentials verification has been done for each allied health professional is present. 2. A document is present showing that the hospital verifies that the 3rd party (allied health professional council) implements the verification process described in the policy and procedure. 3. Audits are conducted to ensure that allied health staff appointments are made according to hospital policy.					

STANDARD #5: Physician staff privileges

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A policy and procedure describes a standardized process to grant clinical privileges to physicians and assign job responsibilities accordingly.	0. There is no professional staff privileging policy and procedure. 1. A policy and procedure describes a standardized process for approving clinical privileges, including the process for approving special and temporary privileges and the training and experience required for new procedures. 2. A core set of privileges is defined for categories of practitioners, e.g. internists and general practitioners, including task-shifting. 3. A current policy and procedure describes how the medical staff credentials are used to assign job responsibilities.					
Level 2. The organization uses a standardized procedure to approve privileges on initial appointment and when new skills have been acquired to each type of physician listed in the policy and procedure. The patient services to be provided by each physician are clearly delineated and communicated by hospital leaders across the organization and to the practitioner.	0. A process for approving privileges in not in place or is inconsistently applied. 1. Each physician has defined core privileges and special privileges (e.g. task-shifting, general practitioner may perform hysterectomy), with evidence of training/experience to perform the special procedure, documented in the personnel file, which has been updated within the past 24 months. 2. Privileges are communicated to relevant departments through a written document. 3. A personnel file is kept for practitioners given temporary privileges (e.g. visiting foreign surgeons) that includes: • Licensure status; • Written request; • Verified information supports a favorable determination regarding the requesting practitioner's qualifications and ability to exercise the requested privileges.					
Level 3. Each privileged practitioner provides only those services that have been specifically permitted by the hospital. The medical staff leaders can demonstrate how the procedure was effective in the appointment process.	0. There is no or inconsistent evidence of monitoring professional practice. 1. All physicians are included in the monitoring and evaluation of professional practice (These may be included in the performance appraisal process, indicators may include complication rates and compliance with clinical practice guidelines. 2. Areas of achievement and potential improvement related to behaviors and clinical results are documented in the personnel file. 3. Findings are used for determining privileges and are reflected in the list of privileges (e.g. if a physician has had surgical complications, their privileges for surgery may be changed.)					

STANDARD #6: Orientation to hospital and jobs

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A policy and procedure for general overall hospital and job-specific orientation for new, reassigned staff, volunteers and contracted workers is available.	0. There is no orientation policy and procedure or it does not address general and job specific orientation expectations and/or all types of staff listed in the standard. 1. A policy and procedure describes orientation expectations for new and reassigned staff, volunteers and contracted workers. 2. The general orientation program includes hospital quality and safety policies and procedures. 3. A job-specific orientation program is developed for each type of position within a department/service.					
Level 2. General and specific job orientation is provided for all new, reassigned staff, volunteers and contracted workers.	0. The orientation programs are not consistently implemented. 1. Staff members hired within the past six months attended general orientation and it is documented on a training register/record. 2. Staff members hired or transferred within the past six months and have completed job-specific orientation and it is documented General orientation of new contracted workers, volunteers and others (e.g. visiting physicians) is provided and documented in their individual files.					
Level 3. All new, reassigned staff, volunteers and contracted workers have received general and specific job orientation.	0. The orientation programs are not monitored. 1. A process is in place to verify whether all new and reassigned staff has completed the general and job specific orientation programs as planned. 2. A process is in place to verify whether all contracted workers, volunteers and visiting professionals have received orientation. 3. The data gathered is used to make improvements in the orientation program. *(**Note**: the orientation may be conducted by the contractor, given that the program content is consistent with the expectations of the hospital, e.g. infection prevention and control (IPC) policies/procedures, fire safety plan. In this case, the contractor needs to provide documentation that the orientation was provided and this document is kept on file.)*					

STANDARD #7: Staff members are competent

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. The hospital has developed a training plan to ensure that staff knowledge and skills are consistent with patient needs.	0. There is no staff training plan and/or it is not based on identified training needs. 1. The hospital has an annual written hospital staff training plan based on assessed training needs (e.g. results of QI monitoring, performance gaps, new procedures, and accreditation surveys). 2. All levels of staff members are included in the plan. 3. Managers develop annual department/service-specific staff training plans to meet the needs of their patients.					
Level 2. The training plan is carried out to meet the educational needs of staff.	0. The majority of training activities have not been carried out as planned. 1. Records of training activities and attendance are kept for each training activity. 2. The majority of the hospital training activities have been conducted as planned. 3. Medical staff presentations are held quarterly and documented regarding case management and current medical articles					
Level 3. The effectiveness of staff training is monitored.	0. Staff training effectiveness is not evaluated. 1. Minutes of staff meetings show that staff which received training outside the hospital shares the learning with other staff in the hospital (e.g. content outline, handouts used). 2. The majority of hospital staff training activities are monitored for training effectiveness. 3. The monitoring data is analyzed and used to improve training effectiveness. ***Note:*** *Effectiveness can be measured by return demonstration of skills or linked with quality monitoring, e.g. improved documentation, hand washing or adherence to policies/procedures or protocols. Staff satisfaction with the training activity is not the intended measure of effectiveness for this standard.*					

STANDARD #8: Sufficient staff to meet patient needs

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. Staffing plans are written in each department that identifies the number of staff needed per shift considering the size of the hospital, the scope of services provided and the workload.	0. Few or no staffing plans have been developed. 1. Each department has a staffing plan, based on the hospital general staffing plan, which includes the number and categories of staff needed per shift. 2. When staffing levels do not meet the needs, policies and procedures are in place that describe actions to be taken, e.g. reassign staff, on-call staff. 3. The majority of staffing plans are based on workload, e.g. nurse to patient ratio, number of tests performed, or number of rooms to be cleaned.					
Level 2. The work schedule provides an adequate number of staff (according to the plan) on each shift to meet the departmental needs.	0. An interview with department heads indicates that schedules are not developed based on the staffing plan. 1. Staffing schedules are filled out according to the plans in a few departments. 2. Staffing schedules are filled out according to the plans; however the number of staff that actually worked in the past month was consistently less than planned in several departments (e.g. a staff shortage occurred 10 times in 30 days). 3. Staffing schedules are filled out according to the plan and much of the time staffing is consistent with the plan (e.g. a staff shortage occurred 5 times or less in 30 days).					
Level 3. Staffing plans are evaluated to determine whether adequate staffing is provided; when shortages exist, leaders set priorities and make adjustments to provide safe care.	0. There is no evaluation of the staffing plans. 1. A review of data regarding staffing planned in relation to the staff that worked is done in each department monthly. 2. When interviewed, department leaders are able to describe how they effectively manage situations in which staffing needs are not met, which is consistent with the policy and procedure. 3. Workload studies are done to evaluate the staffing needs.					

STANDARD #9: Oversight of students/trainees

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A current policy and procedure is available on student oversight.	0. A current policy and procedure regarding student oversight is not present. 1. A current policy and procedure is available on student oversight. 2. A current list of trainees and their assignments is present for each type of program. 3. A list of trainees and their assignments are observed to be posted within relevant units.					
Level 2. The number of trainees and their assignments are known. The current competence (level of training) of each trainee is known, which is used to make assignments and indicate level of required supervision.	0. There is no information available regarding the competency levels of the trainees. 1. Information about competency levels is available for some trainees but not others. 2. Information is available regarding the competence level of each type of trainee. 3. An interview with department heads demonstrate that trainees are assigned patient care consistent with their competency level and clinical oversight is planned in advance.					
Level 3. Monitoring is performed to determine whether the oversight of students is in compliance with the policy and procedure.	0. There is no evidence that the trainees are supervised according to the policy and procedure. 1. The trainee assignment form indicates that all students are supervised according to policy. 2. Orientation records show that all trainees are oriented to the facility's quality and safety policies and procedures. 3. Department records show that student oversight is routinely performed.					

STANDARD #10: Training in resuscitative techniques

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A policy and procedure defines the clinical staff that are required to be trained and at which level (e.g. BLS, ACLS, or PALS). A resuscitation policy and procedure describes how to respond to a resuscitation emergency.	0. The policies and procedures are not written regarding resuscitation. 1. A policy describes CPR training requirements and lists which categories of staff require CPR training and at what level (basic, advanced, pediatric and trauma). 2. A policy and procedure includes: a. Responsibilities for each responder, e.g. CPR, obtaining emergency medications/equipment, administering medications, recording the events, and airway management; b. How to call the resuscitation team; c. Personnel that are to respond; d. Documentation required; e. Evaluation of the resuscitation response. 3. An annual resuscitation training plan is present that includes: a. Identification of staff to be trained; b. Priority staff to be trained; c. Type of training activity; d. # personnel to attend (at least 25% of relevant staff in first year and increment of 25% each subsequent year); e. The training provider; f. Timeframes.					
Level 2. Staff members have successfully completed competency-based training by a qualified instructor and have been retrained within the last two years.	0. Staff training in resuscitation is not proceeding as planned; insufficient staff are trained. 1. The majority of all relevant staff has documentation of training in their roles during resuscitation according to the resuscitation policy and procedure. 2. The resuscitation training is being carried out according to the plan. 3. The majority of staff that attended training has documentation of the required level of competency according the policy and procedure.					
Level 3. There are data that show the impact of the training program that are used to improve the program.	0. There is no evidence that the impact of the CPR training program is used to improve the program. 1. A tool for evaluating the effectiveness of the resuscitation policy and procedure has been designed and tested. 2. Results of the evaluation of resuscitation have been aggregated and displayed. 3. An analysis of the results of resuscitation has been documented and a plan for improvement has been implemented.					

Standard #11: Staff performance management

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A policy and procedure describes the performance management process.	0. There is no policy and procedure for performance management. 1. A current policy and procedure is in place that describes the performance management process. 2. Each category of employee has a job-specific evaluation related to the assigned tasks described in the job description. 3. Staff interviewed is aware of the process.					
Level 2. The performance management process is implemented according to the policy and procedure.	0. Annual evaluations are not done and/or not consistently performed according to the policy and procedure. 1. Personnel files for the majority of staff members contain individual annual performance evaluations conducted within the past 12 months. 2. Two to three performance goals/objectives are set with each employee with a plan to achieve these goals/objectives, which are linked to goals of the organization (e.g. achieving targets). 3. Feedback is provided to each staff member and progress toward the goals/objectives is documented.					
Level 3. The effectiveness of the performance management process is evaluated.	0. The effectiveness of the performance management system has not been evaluated within the past 15 months. 1. A performance program evaluation tool is developed and tested, which measures whether the program functions according to the policy and procedure. At least the following questions are addressed: • Were evaluations done on time? • Did everyone who was supposed to receive an evaluation get one? • Were employee performance goals written and progress noted? 2. An evaluation of the program has been conducted within the past 15 months. 3. The results of the evaluation were analyzed and actions taken to make improvements.					

STANDARD #12: Staff health and safety program

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Over all**
Level 1. A policy and procedure identifies work related injuries and incidents, reporting and management.	0. There is no policy and procedure regarding attending to staff illnesses and injuries. 1. A policy and procedure describes procedures for attending to staff illnesses and injuries. 2. Department heads describe the process for completing incident reports when staff injuries and illnesses occur. 3. Required follow up for incident reports includes staff referral for treatment for illnesses and injuries and the outcomes.					
Level 2. The hospital has a proactive program to identify staff safety risks and has implemented processes to reduce the risks.	0. There is no proactive approach to staff health and safety. 1. An employee occupational hazard risk assessment has been done. 2. Plans are in place to reduce the potential risks to staff; plans include providing the following: a. Hepatitis B vaccine; b. Annual TB tests for staff working in high risk areas: OPD, emergency department, TB unit, laboratory and HIV unit. 3. Documentation in minutes or reports shows that the plans have been implemented. *(**Note:** several of the occupational hazards are related to IPC and are included in the IPC policies and procedures. Other issues may include such things as back injuries or falls)*					
Level 3. The hospital collects and analyzes data on staff risks and injuries and can demonstrate increased safety and reduced health incidents.	0. There is no documentation of employee risks and injuries. 1. The incident report data is aggregated and reported in graphs/charts. 2. An action plan has been developed to reduce employee's risk of injuries. 3. Data analysis shows progress in reducing staff injuries and illnesses.					

RISK AREA #3: SAFE ENVIRONMENT FOR STAFF AND PATIENTS

Required documents	Data Collection Methods
1. List of environmental risks; 2. Facility inspection report (See RA#1, St #11); 3. Facility improvement plan; 4. Facility management plans: a. Fire safety; b. Water management; c. Power management. 5. Hazardous materials inventory, policies and procedures; 6. Material Safety Data Sheets (MSDS); 7. Environmental safety plans, policies and procedures; 8. Biomedical equipment inventory, policies, procedures and replacement plans; 9. Biomedical and non-medical equipment maintenance records; 10. Reports of fire drills; 11. Reports of staff attendance for required training; 12. Reports for monthly safety rounds; 13. Site plan for electrical service distribution; 14. Minutes of Facility Safety Committee; 15. Infection prevention and control focal person job description; 16. Infection prevention and control policies and procedures and plan: a. Hand hygiene; b. Sterilization; c. Laundry and linen services policies and procedures; d. Proper disposal of medical waste; e. Communicable disease reporting. 17. Infection prevention and control surveillance data.	A. Leader interviews; B. Staff interviews; C. Document review; D. Personnel file review; E. Inspection; F. Observation.

STANDARD #1: Regular inspection of environmental safety

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is an inspection process to identify and list health care environment risks of all types.	0. There is no list of environmental risks or it does not include all areas or types of risks. 1. There is a list of environmental risks from all areas, which includes issues identified in facility inspection reports from external agencies. 2. A safety team uses a checklist to identify risks when visiting areas on a monthly basis. 3. There is a comprehensive list of all types of environmental risks in all areas, including those relating to safety, security, hazardous materials, fire safety, biomedical equipment, utilities (power and water), and infection control (e.g. laundry, sterilization, and waste management). ***Note:*** *If during survey, the survey team finds significant risks not included in the hospital's list, then a score of 3 cannot be awarded.*					
Level 2. The risks identified during the inspection process are prioritized according to severity and likelihood of occurrence and a plan is developed to reduce priority risks.	0. The environmental risks have not been prioritized. 1. The risks have been prioritized in some areas but not others. 2. An interview with the biomedical maintenance officer reveals that all risks have been prioritized by the hospital's leadership. 3. The risks have been prioritized by the hospital's leadership using a set of criteria. *(**Note:** The risk criteria would include at least 1) potential severity of an event, injury or failure and 2) likelihood of the event, injury or failure occurring.)*					
Level 3. The risks identified are systematically reduced or eliminated, and the list is updated through periodic, routine re-inspections	0. There is no plan for reducing the risks or it does not include specific responsible parties and target dates for completion. 1. The facility improvement plans include actions to reduce the priority risks. 2. Minutes or reports indicate that the facility improvement plan has been implemented. 3. The implementation of the facility improvement plan is monitored at least quarterly as evidenced in meeting minutes.					

STANDARD #2: Management of hazardous materials

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is an inventory of the all the locations, types, and volume of hazardous materials and a plan for management.	0. There is no list of hazardous materials. 1. There is a list of hazardous materials in some areas/departments. 2. There is a comprehensive list of all types of hazardous materials in all areas. 3. The list is updated on an annual basis.					
Level 2. Based on the plan, hazardous materials are safely and properly labeled, stored, disposed and used.	0. There are no policies and procedures for safe and proper handling, labeling, storage and use of hazardous materials. 1. There are policies and procedures for safe and proper handling, labeling, storage and use of hazardous materials, including material safety data sheets (MSDS) available for staff reference for each of the hazardous materials. 2. Staff is observed to be using appropriate PPE when handling hazardous materials 3. Monthly safety rounds are done to check that hazardous materials are labeled, stored and used properly, which is documented.					
Level 3. Spills and accidents involving hazardous materials are investigated and measures taken to prevent future spills and accidents and/ or improve the response to such spills and accidents.	0. There are no policies/procedures for managing spills or accidents. 1. Policies and procedures are in place on managing spills or accidents with hazardous materials. 2. Staff has been instructed on how to manage spills or accidents (may be included in orientation training). 3. Staff members are able to describe how to handle spills or accidents.					

STANDARD #3: Fire safety program

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is a program for fire safety that is specific to the hospital that includes training, prevention, early detection, and safe exit of staff and patients.	0. There is no fire safety plan. 1. The fire safety plan is present but not specific to this hospital. 2. The fire safety plan has been developed that is specific to the hospital and includes: a. Training; b. Prevention; c. Early detection (e.g., by smoke detectors or regular patrols); d. Communication (e.g. by electronic or manual alarm or use of whistles); e. Abatement (e.g. by extinguishers or functional fire hose), and f. Safe exit of staff and patients. 3. Documentation shows that the fire safety plan was developed in collaboration with the fire brigade/police.					
Level 2. The fire program has been implemented throughout the organization and sufficient equipment is available and functioning.	0. There has been no or limited staff trained in the fire safety plan. 1. The majority of the staff has received training in fire safety within the past 12 months. 2. The staff is able to describe how they would respond to a fire and evacuate patients. 3. Sufficient fire equipment (extinguishers, water hoses and water supply, and exit signage) is available and functioning through routine maintenance. ***Note:*** *The training should not be limited to the use of fire extinguishers staff need to be trained in all aspects of the fire plan, e.g. staff need to practice their specific roles/responsibilities.*					
Level 3. The fire program is tested annually and the results are used to continually improve fire safety.	0. There are no monthly fire safety rounds. 1. Fire safety rounds are conducted monthly and actions taken to correct issues, e.g. locked fire exits or blocked fire extinguishers. 2. A fire drill has been conducted within the past 12 months, which is conducted in collaboration with the fire brigade and evaluated. 3. A plan for improvement is developed and implemented based on findings of safety rounds and the fire drill evaluation.					

STANDARD #4: Biomedical equipment safety

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is an inventory of all biomedical equipment and a replacement plan and comprehensive program for inspecting, testing, and maintaining biomedical equipment by qualified individuals is carried out.	0. There are no policies and procedures and/or replacement plan for biomedical equipment. 1. Policies and procedures are in place and a replacement plan for biomedical equipment. 2. Each piece of biomedical equipment has an inventory number attached to it and a complete inventory of biomedical equipment is present. 3. All staff that maintain the equipment is trained.					
Level 2. All biomedical equipment is appropriately inspected, tested, and maintained. Only trained and competent people handle specialized equipment.	0. Biomedical equipment has not been inspected and tested. 1. All equipment is tagged with date of inspection / maintenance and next due date. 2. Equipment management records show that all biomedical equipment is inspected, tested and maintained on a scheduled basis by trained individuals. 3. All staff that handles specialized equipment is trained and this is documented in their personnel file. ***Note:*** *Identify staff members who handle specialized equipment, e.g. ventilators, anesthesia machines, sterilizers and review their personnel files to determine that they have been trained.*					
Level 3. Data related to the program are used to reduce equipment breakdown and reduce risk to patients and staff.	0. The biomedical maintenance report does not reflect the biomedical equipment maintenance plan. 1. The biomedical maintenance report reflects the facility maintenance plan (may be evidenced through the biomedical maintenance software). 2. The types of equipment and breakdowns are analyzed and reported to the safety committee at least quarterly. 3. Actions are taken to reduce risks identified through data analysis.					

STANDARD #5: Stable safe water sources

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A plan describes the processes for maintaining a safe water supply.	0. There is no plan for water management. 1. There is a plan for water management, which includes current water sources and suppliers. 2. The plan outlines methods to conserve water use 3. Agreements are in place for obtaining emergency water supplies for drinking					
Level 2. A stable source of safe water and alternate sources are available; uninterrupted sources of clean water are available to support essential processes for patient care.	0. There is inconsistent availability of safe water sources. 1. Alternate sources of safe drinking water are available. 2. All water containers are observed to be clean. 3. Supplies are routinely available to test water.					
Level 3. The hospital ensures that the water is treated regularly and tested; the results are used to ensure patients have an uninterrupted supply of safe water.	0. There are no or inconsistent testing and treatment of water sources. 1. Records show that the water sources are tested on a weekly basis by the Environmental Health Officer, including pH and chemical testing. 2. Records show that water treatment is performed every five weeks or as needed by the hospital Environmental Health Officer. 3. An evaluation of the management of water shortages is conducted and the results of the evaluation are used to make improvements in maintaining a safe water supply.					

STANDARD #6: Stable electricity sources

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Essential equipment and processes requiring electricity that support patient care have been identified.	0. There is no plan for power management. 1. There is a plan for power management that describes the processes for maintaining electrical power to meet emergency needs. 2. A site plan showing electrical service entrance, distribution system, service transformer, and emergency generator location is posted in the power plant. 3. Critical areas and equipment requiring back up have been identified in the plan, e.g. NICU, ventilators.					
Level 2. A process is in place to ensure an uninterrupted source of electrical power to essential equipment and processes.	0. Alternate sources of electrical power are not available and/or well maintained. 1. Alternate sources are of power are available. 2. Maintenance staff interviewed can describe how to carry out the power management plan. 3. Maintenance practices for emergency power systems are carried out according to policy and procedure and documented					
Level 3. The organization tests the utilities program and uses the information to ensure patients are safe if electrical power is interrupted.	0. There are no or inconsistent testing of backup electric power. 1. The backup generator(s) is tested and documented on a weekly basis, including that there is sufficient oil/gasoline to run them. 2. Emergency equipment that uses back up batteries (e.g. defibrillators) and UPS systems (e.g. for neonatal incubators or other critical equipment) are routinely tested at least quarterly. 3. Actions are taken and documented to ensure reliability of the sources.					

STANDARD #7: Coordination of infection prevention and control program

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A position description exists for an infection prevention and control (IPC) focal person, which is included in the personnel file.	0. There is no IPC focal person or no current job description. 1. The IPC job description has been reviewed/ updated within the past 24 months. 2. The job description of an IPC focal person includes roles and responsibilities regarding: a. Program management; b. Infection prevention and control activities; c. Quality improvement and risk management; d. Infection control committee. 3. The IPC has sufficient time allotted to carry out the roles and responsibilities, e.g. routine surveillance of infections, data management. (Note: this will be a judgment based on observations that the program is being carried out as planned).					
Level 2. The focal person has received sufficient training in infection prevention and control to fulfill the job responsibilities.	0. The IPC focal person has not received training in infection prevention and control. 1. The IPC focal person has attended a general training program (e.g. at least a 2-day workshop conducted by qualified individuals) in infection prevention and control. 2. The focal person attends annual training activities to maintain and build capacity in current infection prevention and control practices. 3. The focal person successfully completes a competency-based infection prevention and control certification course provided by qualified trainers.					
Level 3. A qualified IPC focal person carries out surveillance, data gathering, aggregation and analysis of infection prevention and control data and trains other staff in IPC practices.	0. The IPC focal person does not carry out routine surveillance activities. 1. Data shows that the IPC focal person conducts routine surveillance for infection risks according to current practice guidelines (e.g. CDC). 2. Meeting minutes reflect that the IPC focal person guides IPC data analysis and action planning activities. 3. The IPC guides the development and staff training of the IPC policies and procedures.					

STANDARD #8: Reduction of health care associated infections through hand hygiene

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Hand hygiene is emphasized and guided by evidence-based guidelines.	0. There are no hand hygiene policies/procedures. 1. There are hand hygiene policies/procedures based on current practices (e.g. WHO). 2. The majority of departments have communicated the policies/procedures to staff (e.g. in-service training, posters above sinks). 3. Staff interviewed is aware of hand hygiene policies and procedures.					
Level 2. A consistent and effective hand hygiene program is in place with adequate equipment and supplies.	0. Adequate hand washing/hygiene facilities and supplies (including water, soap, disposable towels, and / or alcohol hand gel) are not consistently available. 1. Adequate hand washing/hygiene facilities and supplies are observed to be conveniently located for staff use. 2. The in-charge describes a systematic process for ensuring availability of adequate supplies is evident, e.g. use of a daily checklist. 3. The majority of staff is observed performing hand hygiene according to the policies/ procedures.					
Level 3. Infection prevention and control data and hand hygiene surveillance data are used to improve the program.	0. No data or incomplete data is collected regarding hand hygiene practices. 1. A standardized hygiene observation tool and method is used to collect data. 2. Data are collected in all clinical areas on a scheduled basis. 3. The data are aggregated and used to identify gaps and develop improvement plans.					

STANDARD #9: Effective sterilization processes

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Sterilization processes are guided by evidence-based policies and procedures carried out by competent staff with adequate equipment and supplies.	0. The required sterilization policies or procedures are not present and/or complete. 1. Current evidence-based policies and procedures are written for: a. Decontamination and disinfection processes for surgery, CSSD, and patient care units; b. Decontamination and disinfection processes for laundry, kitchen, and cleaning (housekeeping); c. Sterilization techniques (e.g., sterilization times, temperatures, and humidity); d. Reuse of single use devices. 2. Each person who reprocesses instruments receives initial and annual competency testing. 3. Equipment and supplies necessary to carry out the policies and procedures are present and in good working order.					
Level 2. A consistent and effective sterilization process is in place.	0. Sterilization processes are not functioning or observed to create a potential for cross-contamination. 1. Cross-contamination is observed to be prevented in the CSSD cleaning area. 2. Staff interviewed indicates that before use on each patient, critical medical and surgical devices and instruments are sterilized, including dental instruments (e.g., extraction forceps, scalpel handles). 3. Staff interviewed indicates that at a minimum, high-level disinfection is provided for semi-critical patient care equipment (e.g., gastrointestinal endoscopes, endotracheal tubes, anesthesia breathing circuits, and respiratory therapy equipment).					
Level 3. There is documented evidence that complete sterilization has been accomplished.	0. Processes (e.g. indicators) to verify complete sterilization are not present or inconsistent. 1. Policies and procedures are in place for each type of monitoring technique including: a. How to perform the testing; b. How often testing should be done; c. How the results are documented; d. Timeframe for maintaining sterilization records. 2. Mechanical and chemical monitors are used to ensure the effectiveness of the sterilization process and results are documented. 3. Documentation indicates that each load is monitored with mechanical (e.g., time, temperature, pressure) and chemical (internal and external) indicators (If the internal chemical indicator is visible, an external indicator is not needed).					

STANDARD #10: Effective laundry and linen services

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Current evidence-based policies and procedures guide the operation of laundry and linen services. .	0. Laundry and linen policies and procedures are not present, incomplete or out-of date. 1. Current policies and procedures are present based on evidence-based guidelines. 2. There are procedures for collecting, labeling, and laundering of linen contaminated with hazardous materials or body fluids.[1] 3. Staff members interviewed is aware to the policies and procedures.					
Level 2. Consistent and effective laundry and linen processes are in place with adequate equipment and supplies.	0. The washing machines are not functional or the capacity is not sufficient to meet the demands. 1. There is an adequate supply of functioning automated washing machines, and water. 2. Adequate, acceptable cleaning supplies and detergents are available to meet workload demands. 3. Operation of laundry and linen services is observed to be carried out according to the policies and procedures including good separation of clean and dirty processes					
Level 3. There is a quality control program for laundry and linen services.	0. There is no quality control plan for laundry and linen services or it is inconsistently carried out. 1. The quality control plan includes: a. Recommended water temperatures and cycle time for laundry to be maintained; b. Equipment preventive maintenance, cleaning and disinfection, and decontamination schedule based on the operation performed; c. Load size based on the equipment manufacturer's recommendations; d. Cleaning of washing machines and filters in the dryers; e. Maintenance records related to any problems experienced and actions taken. 2. Records indicate that the plan is being followed. 3. Action plans are developed and implemented to address quality control issues.					

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

STANDARD #11: Reduction of health care associated infections

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. An infection prevention and control plan with measurable quality goals is in place that guides the implementation of the program.	0. There is no IPC program. 1. There is an IPC program based on current practices including an IPC focal person, a functional committee, policies and procedures and a plan with measurable goals. 2. There is annual training of all staff regarding IPC based on identified needs. 3. Staff interviewed is aware of the IPC policies and procedures.					
Level 2. Risks of health care associated infections are identified for patients, staff, and visitors and measures taken to reduce the risks.	0. Risks of infection have not been identified for patients, staff and visitors. 1. Risks of infection have been identified for patients, staff and visitors. 2. Policies and procedures are developed to manage risks that are identified. 3. The staff is observed to be carrying out the IPC policies and procedures.					
Level 3. The infection prevention and control program is evaluated for effectiveness in reducing the incidence of health care associated infections, through monitoring infection rates.	0. The infection prevention and control program has not been evaluated. 1. The surveillance data are aggregated, analyzed and displayed in relevant departments by type of infection, e.g., urinary tract, blood stream, and surgical site infections. 2. The data are used to develop and implement plans for reducing infection rates. 3. The overall infection prevention and control program is evaluated every 12 months and improvements made based on findings.					

STANDARD #12: Barrier techniques available and used

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. The situations in which barrier techniques are to be used have been identified; policies and procedures developed and made known to staff.	0. There are no policies or some clinical departments are missing policies and procedures regarding use of personal protective equipment (PPEs). 1. Policies and procedures regarding use of PPEs based on current practice are available in all clinical areas. 2. The staff has been trained regarding the use of PPEs. 3. The staff interviewed is aware of the proper use of PPEs.					
Level 2. Barrier techniques are used for those identified situations, supplies are available and accessible, and the techniques are used correctly.	0. PPEs are not consistently available in all departments as required. 1. PPE supplies and equipment are available and convenient to staff in all locations. 2. The majority of staff is observed using the PPEs according to recommended practice. 3. Isolation rooms are available and equipped according to recommended practice.					
Level 3. There are data on the use of barrier techniques that contributes to the continuous improvement in correct use.	0. Data are not collected regarding the use of PPEs. 1. Data are collected regarding the use of PPEs. 2. The data are aggregated, analyzed and displayed. 3. The data are used to develop and implement plans for improving use of PPEs.					

STANDARD #13: Proper disposal of sharps and needles

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A policy and procedure provides guidance on proper disposal of sharps and needles, which is made known to staff.	0. There are no policies and procedures regarding disposal of sharps and needles. 1. Policies and procedures regarding disposal of sharps and needles are based on current practice. 2. Staff interviewed is aware of the proper disposal of sharps and needles. 3. Sufficient supplies of sharps containers are observed to be available in all relevant locations.					
Level 2. The disposal of sharps and needles is well organized and uniform, with disposable containers collected regularly and disposed of properly.	0. The disposal of sharps and needles is not well organized and uniform. 1. Puncture-proof sharps containers are properly located in all relevant areas. 2. Containers are observed to be no more than 3/4 full, sealed and disposed of according to policy/procedure. 3. The sealed sharps containers are picked up on a routine schedule and stored in a separate, secured storage area.					
Level 3. There are data available on injuries and accidents related to sharps and needles; these data are then used to continually improve the program.	0. No data are collected related to needle sticks or sharps injuries. 1. Data are collected related to needle sticks and sharps injuries. 2. Results of data are communicated to the Infection Prevention and Control Committee at least quarterly. 3. Data are used to develop and implement plans to reduce the potential for injury.					

STANDARD #14: Proper disposal of infectious medical waste

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies and procedures describe proper disposal of medical waste.	0. There are no policies and procedures regarding disposal of infectious medical waste. 1. There are current evidence-based policies and procedures regarding disposal of infectious medical waste. 2. Staff is oriented on proper disposal of infectious medical waste. 3. Staff interviewed in all areas is able to describe proper disposal of infectious medical waste.					
Level 2. A uniform disposal process is used that includes all types of infectious waste collection and proper disposal. Equipment and supplies necessary to manage medical waste are routinely available.	0. The equipment and supplies for disposing of infectious waste is inconsistently available. 1. The equipment and supplies are available for disposing of infectious waste. 2. Infectious waste is observed to be segregated, bagged and labeled according to policy and procedure. 3. The disposal sites, including incinerators, are observed to be well maintained and secure.					
Level 3. The infectious medical waste disposal process is part of the organization's infection prevention and control process and is regularly evaluated and improved when indicated.	0. The proper disposal of medical waste is not evaluated on a regular basis. 1. There is a scheduled (at least monthly) and implemented system for the inspection of waste disposal. 2. The results of the inspection are documented and reported to the Infection Prevention and Control Committee. 3. Actions are taken to correct issues identified.					

STANDARD #15: Prevention, control and monitoring of communicable diseases

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies, procedures and protocols are in place for the prevention and control of communicable diseases	0. Current policies, procedures and protocols are not in place regarding managing communicable diseases. 1. Current national treatment protocols for HIV/AIDs, malaria, respiratory tract infections, diarrheal diseases and TB are available. 2. Prevention programs are established based on identified community needs. 3. An outbreak management policy and procedure is in place.					
Level 2. Prevention and control policies, procedures and protocols are carried out.	0. Programs to prevent and control communicable diseases are not effectively managed. 1. Effective promotional and education programs are provided to staff and community regarding prevention of communicable diseases. 2. The childhood vaccination program and supply chain is implemented according to the guidelines and vaccination plan. 3. Screening programs are in place to identify communicable diseases (e.g., sexually transmitted infections and HIV).					
Level 3. Communicable diseases are reported and data are used to plan promotional and service delivery.	0. Communicable diseases are not reported according to MOH requirements. 1. Communicable diseases are reported according to MOH requirements. 2. The success of control and prevention efforts is evaluated on an annual basis. 3. Communicable disease data is monitored and the data is used to plan promotional and service delivery.					

Risk area #4: CLINICAL CARE OF PATIENTS

Required documents	Data Collection Methods
1. Patient identification policy and procedure; 2. Informed consent policy and procedure; 3. Patient assessment policy and procedure; 4. Laboratory policies and procedures, quality control and safety manual; 5. Radiology policies and procedures, quality control and radiation safety; 6. Policies and procedures regarding patient care planning; 7. High risk patients and procedures; 8. Maternal and child health policies, procedures and protocols; 9. Anesthesia and surgical services policies and procedures; 10. Triage process; 11. Emergency equipment and supplies lists, policies and procedures; 12. Ambulance services policies and procedures; 13. Ambulance service job descriptions; 14. Medication use policies and procedures and medication errors; 15. Patient education policies and procedures; 16. Referral and transfer policies and procedures; 17. Staff training records.	A. Leader interviews; B. Staff interviews; C. Document review; D. Medical record review; E. Personnel file review.

STANDARD #1: Correct patient identification

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A policy and procedure describes when and how patients are to be properly identified, which includes two patient identifiers when providing care, treatment or services.	0. There is no policy and procedure regarding identifying patients. 1. A policy and procedure identifies when patient identification is required. 2. A policy and procedure requires the use of two patient identifiers (not the use of the patient's room number or location), which includes identification of newborns. 3. The policy and procedure has been approved and is dated within the past 24 months.					
Level 2. The identification process is fully implemented and followed.	0. None of the staff members are able to state the two identifiers that are in the policy and procedure. 1. All staff members interviewed is able to describe when patient identification is required. 2. All staff members interviewed is able to state how to correctly identify patients. 3. A time out process is in place to ensure that patients undergoing procedures are identified, which is documented (links with use of surgical checklist – see Risk Area #4, Standard 15).					
Level 3. Monitoring data are used to continually improve the identification process.	0. No data was found regarding monitoring of patient identification. 1. Accurate and complete data is collected to determine if the staff is following the procedure. 2. Data regarding patient identification is aggregated, displayed and analyzed. 3. Minutes or other documents show that actions were taken to improve patient identification.					

STANDARD #2: Informed consent

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A policy and procedure describes expectations for providing information to patients regarding their treatment and procedures, taking of photographs and granting informed consent.	0. There is no policy and procedure regarding obtaining informed consent. 1. An informed consent policy and procedure is written and approved within the past 24 months. 2. The policy and procedure indicates that the patient will be informed of: a. their condition b. the proposed procedures and treatment(s) and who is authorized to perform the procedure or treatment c. potential benefits and drawbacks to the proposed treatment(s) and possible problems related to recovery. d. possible alternatives to the proposed treatment(s) and possible results of non-treatment. e. the likelihood of successful treatment(s). f. the identity of the physician or other practitioner responsible for their care. g. photographs that will be taken including the time and purpose 3. The consent form contains the same elements as above and is available in languages common to the patient populations served.					
Level 2. Informed consent is obtained before surgery, anesthesia, use of blood and blood products, and other high-risk treatments and procedures identified by the hospital.	0. The majority of medical records were missing a signed and dated consent form. 1. The majority of medical records reviewed had complete signed consents. 2. The medical progress notes indicate that the patient was informed of all of the elements required for informed consent (see Level 1) 3. All patients interviewed indicate that they have been well informed prior to signing the consent.					
Level 3. The consent process is evaluated and improved based on patient and staff data and on its effectiveness in supporting patient rights to participate in the care process.	0. No data exists regarding monitoring of informed consent. 1. Accurate and complete data is collected to determine if the staff is following the procedure. 2. Data regarding informed consent are aggregated, displayed and analyzed. 3 Minutes or other documents show that actions were taken to improve informed consent. .					

STANDARD #3: Medical assessments complete and timely

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. The content and timeframes for conducting medical assessments (including initial and reassessments) are defined and standardized for specific patient populations, e.g. maternity, pediatric, mental health, emergency and outpatients.	0. There are no policies and procedures regarding performing patient assessments. 1. A policy and procedure describes the content of assessments that are to be conducted by physicians, e.g. history and physical assessment. 2. Policies and procedures outlines different expectations for each type of patient, e.g. pediatric, emergency, outpatient and maternity and the timeframes for which the assessments and reassessments are to be done, e.g. an Emergency Department (ED) assessment would be expected to be done more rapidly than elective admissions. 3. The assessment forms are designed to collect the information required. ***Note:*** *Assessments of patients in specialty areas are to be located in the department policies and procedures.*					
Level 2. Medical assessments are standardized and timely to meet patient needs.	0. The correct medical assessments are not done based on the type of patient. 1. The correct assessment was done based on the type of patient, e.g. ICU, medical, pediatric, maternity. 2. In the majority of the medical records reviewed, the medical assessments are complete. 3. In the majority of the records, the assessments are completed within the expected time frame (Note: this is determined according to the time of patient arrival to the area/ department compared with the time that the assessment was done.)					
Level 3. The content and timeliness of medical assessments are monitored to improve the assessment process in meeting patient needs.	0. No data was found regarding monitoring of documentation of assessments. 1. Accurate and complete data is collected to determine if the staff is following the policy. 2. Data regarding assessments are aggregated, displayed and analyzed. 3. Minutes or other documents show that actions were taken to improve documentation.					

STANDARD #4: Nursing assessments complete and timely

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. The content and timeframes for conducting nursing assessments (including initial and reassessments) are defined and standardized for specific patient populations, e.g. maternity, pediatric, mental health, emergency and outpatients.	0. There are no policies and procedures regarding performing patient assessments. 1. A policy and procedure describes the content of assessments and reassessments that are to be conducted by nurses. 2. Policies and procedures outline different expectations for each type of patient/unit, e.g. pediatric, emergency, outpatient, ICU, and maternity and the timeframes for which the assessments and reassessments are to be done. 3. The assessment forms are designed to collect the information required. ***Note:*** *Assessments of patients in specialty areas may be located in their department policies and procedures.*					
Level 2. Nursing assessments are standardized and timely to meet patient needs.	0. The nursing assessments are not correct based on the type of patient. 1. The correct assessment was done based on the type of patient, e.g. ICU, medical, pediatric, maternity. 2. In the majority of the medical records reviewed, the nursing assessments are complete. 3 In the majority of the records, the assessments are completed within the expected time frame. (Note: this is determined according to the time of patient arrival to the area/ department compared with the time that the assessment was done.)					
Level 3. The content and timeliness of nursing assessments are monitored to improve the assessment process in meeting patient needs.	0. No data was found regarding monitoring of documentation of assessments. 1. Accurate and complete data is collected to determine if the staff is following the policy. 2. Data are aggregated and displayed in graphs and charts regarding assessments. 3. Minutes or other documents show that actions were taken to improve documentation.					

STANDARD #5: Laboratory services available and reliable

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Current laboratory policies, procedures and safety manual is available to staff.	0. There are no policies and procedures regarding performing lab tests. 1. Laboratory policies, procedures and safety manual are present, which have been approved within the past 24 months. 2. A list of normal ranges, turnaround times and critical values are defined and made available to all clinical staff. 3. The hospital scope of services indicates that the expected facility-level package of investigations is delivered by qualified staff					
Level 2. Clinical laboratory services are consistently available to meet patient needs, and results are reliably reported, including critical lab results, in a timely manner by qualified individuals in a standardized format using established ranges.	0. Effective processes are not in place to collect and transport specimens. 1. Effective and timely processes are used to collect and transport specimens to the laboratory; rejected specimens and turnaround time are monitored. 2. Stock record review / inventory indicate that reagents and required materials are routinely available to perform the required lab tests. 3. Lab results are documented and located in the same location of the medical records reviewed; critical lab results reported by telephone require a “write down” and “read back” process.					
Level 3. Clinical laboratory quality control is performed for lab tests and oversight is provided for tests performed/collected outside the laboratory; data are used to improve accuracy of results.	0. There is no current laboratory quality control manual. 1. A current laboratory quality control manual is present. 2. Laboratory quality control is run and documented at the beginning of each shift. Data that exceeds quality control tolerance limits is acted upon immediately. 3. External quality control results are at least 95% in concordance with the national reference laboratory.					

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

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Current radiology policies, procedures and safety manual are available.	0. There are no current radiology policies and procedures. 1. Radiology policies and procedures are present, which have been approved within the past 24 months. 2. A radiation safety manual is available based on current evidence-based practices. 3. Staff interviewed is aware of the policies, procedures and safety practices.					
Level 2. Diagnostic imaging services are consistently available to meet patient needs, the radiation safety program meets all legal requirements, and the tests are conducted and reported by qualified individuals in a timely manner.	0. Radiology results are not reported in a timely manner. 1. All radiology results are documented and located in the same location within the medical records. 2. The hospital scope of services indicates that the expected service-level package of investigations is delivered and the master staffing schedule for radiology shows that qualified staff members are scheduled 24 hours per day (or there is someone on call). 3. Staff is observed to be in compliance with using the required PPEs including radiation monitors, lead apron, lead gloves, and lead goggles.					
Level 3. Diagnostic imaging quality control is performed for imaging tests and oversight is provided for tests performed outside the radiology department; data are used to improve accuracy of results.	0. There is no radiology register. 1. A radiology register is kept that contains number, date, given name and family name, sex, age, address (sector, cell and district), type of x-ray requested, requesting doctor and number of retakes. 2. A current radiology quality control manual is present; quality is monitored and actions taken to make improvements (includes analyzing and acting upon retake data). 3. Radiation monitors are tested regularly for the exposure limits by certified authorities. ***Note:*** *Check to see if there is a portable x-ray machine used and if so, it must also meet the quality control expectations.*					

STANDARD #7: Written plans for care

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A policy and procedure is written to provide guidance on documentation for care planning and provision.	0. Policies and procedures regarding planning patient care and discharge are incomplete. 1. A current policy and procedure describes the process for developing patient plans of care to include: Individual treatment or care plans are prepared and documented a) Based on the assessment of patient/service user needs, including the results of diagnostic tests where relevant; b) Involve the patient and their families when appropriate, and c) Include the goals or desired results of the treatment or care; d) Physician's plans of care contain a notation of the subjective and objective findings, assessment and plan with goals; e) Nursing care plans consist of a nursing diagnosis, nursing interventions and expected outcomes. 2. Forms are readily available to staff for writing the plan of care. 3. Clinical staff receives training/mentoring in writing and implementing effective plans of care. (***Note:*** *Initiating a standard protocol is a plan of care).*					
Level 2. Planning patient care is collaborative (e.g., physicians and nurses) with written care plans, including discharge planning, that are relevant to the patient's current condition.	0. The majority of the medical records do not have medical and nursing plans of care. 1. The plans of care are written according to the policy and procedure. 2. Plans of care are consistent with current treatment guidelines. 3. Discharge planning needs are identified in the plan of care.					
Level 3. Patients' needs are reassessed and progress toward goals monitored and documented.	0. Patient care plans are not updated based on changing needs. 1. Patients' needs are reassessed daily and the treatment or care plan is revised according to reassessment results. 2. Patients' progress in achieving the goals or desired results of treatment, care or service is monitored and documented. 3. A collaborative team meeting (including physicians, nurses, patient/family and other care givers as indicated) is conducted for patients that are hospitalized for more than 10 days to discuss and revise the plan of care.					

STANDARD #8: Clinical protocols available and used

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Clinical protocols are adopted for the most common diagnoses/ conditions and procedures to guide clinical practice.	0. A policy and procedure for adopting clinical protocols is not available. 1. A policy and procedure for adopting clinical protocols is available. 2. Treatment guidelines, protocols, algorithms and/or clinical pathways have been adopted based for at least five common diagnoses/conditions, including at least: a. Diabetes mellitus; b. Malaria; c. Hypertension; d. Congestive heart failure. 3. The protocols are based on current evidence, are referenced and approved by the medical staff.					
Level 2. Treatment guidelines and protocols are used to guide the management of priority patients and procedures.	0. The treatment guidelines and protocols are not consistently used to guide practice. 1. Treatment guidelines and protocols are observed to be readily available to staff in the units. 2. All relevant staff interviewed is familiar with the treatment guidelines and protocols. 3. Documentation in the majority of reviewed medical records indicates that the treatment guidelines and protocols are implemented.					
Level 3. Compliance by individual healthcare providers (nurses, physicians or others) is monitored.	0. There is no monitoring of compliance with treatment guidelines and/or protocols. 1. Data are collected, aggregated and analyzed regarding use of the treatment guidelines and/or protocols. 2. The data are tracked by individual healthcare workers (nurses, physicians or others). 3. The results are included as part of the healthcare workers' performance improvement evaluation.					

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

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is a list of types of patients and clinical procedures provided by the hospital that are considered high risk and protocols have been developed based on current evidence.	0. There is no list of high risk patients and procedures. 1. The high risk patients (e.g. nutritional deficits, potential for falls, long term conditions, comatose, mental health and those requiring palliative care) and clinical procedures (e.g. patients receiving sedation, dialysis, chemotherapy, blood transfusions or are on ventilators) are identified. 2. Protocols are available for all of the high risk patients and procedures on the list. 3. The protocols are developed by a multidisciplinary team (physicians, nurses, physiotherapists when indicated).					
Level 2. Relevant staff has implemented protocols to guide care for all patients and procedures on the list, and staff are educated on the protocols.	0. There is no evidence that the protocols have been effectively implemented. 1. Protocols are observed to be readily available to staff in the units. 2. All relevant staff interviewed is familiar with the protocols. 3. Documentation in the majority of reviewed medical records indicates that the protocols are implemented.					
Level 3. Use of the protocols is monitored and these data is used to enhance staff training and improve use.	0 There is no documentation that shows that the implementation of these protocols has been monitored. 1 A checklist or other tool is being used to monitor at least one of the high risk procedures and one of the high risk patient protocols. 2 There are analyses of the findings of each and action plans that show that results of the monitoring were acted upon during the past 12 months. 3 Feedback is given to staff regarding the results to improve patient care.					

STANDARD #10: Complete maternal health care

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A register of pregnant women and family planning clients is kept. Essential guidelines for reproductive and maternal health[2] are adopted or adapted according to current evidence.	0. A register of maternal health referrals and family planning clients is not kept. 1. A register is kept of all maternal health referrals and family planning clients. 2. Current evidence-based (with references) protocols, approved within the past 24 months, are available for prioritized maternal health conditions. Required protocols include: a. Normal delivery; b. Cesarean section; c. Post partum hemorrhage; d. Post partum sepsis; e. Pre-eclampsia. 3. The protocols are observed to be readily available to staff members in the clinical area.					
Level 2. Protocols are implemented and essential equipment and supplies to meet patient needs for reproductive (including family planning) and maternal health are available.	0. The majority of staff are not aware of the clinical protocols. 1. Relevant staff members interviewed is aware of the clinical protocols. 2. Supplies and equipment are available for providing reproductive and maternal health services according to the protocols (refer to Reproductive and Maternal Health checklist) 3. A review of medical records reveals that documentation of patient care indicates that the protocols are implemented. *(**Note:** Select a protocol for reproductive and maternal health to determine whether the documentation reflects that the protocol was followed)*					
Level 3. Monitoring data include measurement of implementation and outcomes of priority protocols and adequacy of supplies.	0. There is no documentation that shows that the implementation of these protocols has been monitored. 1. Availability of supplies and equipment are monitored. 2. Data are collected and analyzed regarding compliance with priority protocols. 3. Action plans show that results of the monitoring were acted upon during the past 12 months.					

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

STANDARD #11: Complete child health care

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Protocols for newborn and child health[3] are adopted or adapted according to current evidence.	0. Protocols are not available for newborn and child health. 1. Some protocols are available for newborn and child health. 2. Current evidence-based (with references) protocols, approved within the past 24 months, are available. Required protocols include: a. Asphyxia (hypoxic encephalopathy); b. Neonatal sepsis; c. Prematurity. 3. The protocols are observed to be readily available to staff members in the clinical area.					
Level 2. The protocols are implemented and essential supplies to meet patient needs for newborn and child health are available.	0. Staff are not aware of the newborn and child health protocols. 1. Relevant staff members interviewed is aware of the protocols. 2. Supplies and equipment are available for providing services according to the protocols. 3. The majority of the reviewed medical records reveal that documentation of patient care (including malnutrition cases) indicates that the protocols are implemented. *(**Note:** Select protocol for neonatology and malnutrition cases to determine whether the documentation in the record reflects that the protocol was followed.)*					
Level 3. Monitoring data include measurement of implementation and outcomes of priority protocols and adequacy of supplies.	0. There is no documentation that shows that the availability of supplies and equipment is monitored. 1. Availability of supplies and equipment are monitored. 2. Data are collected and analyzed regarding compliance with priority protocols. 3. Action plans show that results of the monitoring were acted upon during the past 12 months.					

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

STANDARD #12: Comprehensive HIV prevention and care

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A comprehensive HIV prevention and care program is established.	0. A policy on HIV testing based on national testing guidelines is not available. 1. There is a policy on HIV testing based on national testing guidelines. 2. Current evidence-based (with references) protocols, approved within the past 24 months, are available for: a. Provider-initiated testing (PIT); b. Confidentiality of test results; c. Assessing for opportunistic infections, e.g. TB; d. Prevention of mother-to-child transmission; e. Treatment of children; f. Antiretroviral therapy; g. People living with HIV; h. Caregiver education; i. Referral for treatment and social needs; j. Pain management; k. Palliative care. 3. The protocols are readily available to staff members in the clinical area.					
Level 2. The protocols are implemented and essential supplies to meet patient needs for comprehensive HIV prevention and care are available.	0. Supplies and equipment for HIV prevention and care are not consistently available. 1. Supplies and equipment are available for providing services according to the protocols. (Refer to HIV checklist) 2. Staff interviewed is knowledgeable of the current protocols. 3. The majority of the reviewed medical records reveal that documentation of patient care indicates that the protocols are followed. (Refer to tool)					
Level 3. Monitoring data include measurement of implementation and outcomes of priority protocols and adequacy of supplies.	0. There is no documentation that shows that availability of supplies and equipment is monitored. 1. Availability of supplies and equipment are monitored. 2. Data are collected and analyzed regarding compliance with priority protocols. 3. Action plans show that results of the monitoring were acted upon.					

STANDARD #13: Comprehensive tuberculosis prevention and care

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Comprehensive tuberculosis prevention and treatment is available including a specialized unit, necessary laboratory services and treatment guidelines.[4],[5]	0. A specialized unit for managing tuberculosis is not available and/or it does not meet the established criteria. 1. A specialized unit and structure for managing tuberculosis is in place that meets established criteria (see TB checklist). 2. A laboratory and supplies are available to carry out reliable microscopic sputum tests and GeneXpert and to send specimens for cultures and drug resistance to the reference laboratory. 3. Current policies, procedures and evidence-based (with references) protocols, approved within the past 24 months, are available for: a. Screening and diagnostic guidelines; b. Triage guidelines for emergency and outpatient departments; c. Test results reporting; d. Maintaining a TB registry; e. Retreatment regimen; f. Infection prevention and control; g. Directly observed therapy (DOT); h. Contact tracing; i. Patient/family education (instructions on therapy and transmission prevention); j. Community education (early symptoms and treatment availability); k. TB prevention in HIV-infected patients; l. Medical follow up and referral; m. Referral to specialized facilities for treatment of MDRO.					

[4] WHO. Guidelines for the Programmatic Management of Drug-Resistant Tuberculosis 2011 Update. Available at: http://whqlibdoc.who.int/publications/2011/9789241501583_eng.pdf
[5] CDC. Plan to Combat Extensively Drug-Resistant Tuberculosis Recommendations of the Federal Tuberculosis Taskforce 2009. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5803a1.htm?s_cid=rr5803a1_e

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 2. The policies, procedures and protocols are implemented and essential supplies to meet patient needs for comprehensive TB prevention and care are available.	0. Drug supplies are not consistently available for TB care/treatment. 1. Supplies of drugs are available for providing treatment according to the protocols. (Refer to checklist) 2. Specialized staff is consistently assigned to the unit that is knowledgeable of the current protocols. 3. The majority of the reviewed medical records reveal that documentation of patient care indicates that the protocols are followed. (Refer to tool)					
Level 3. Monitoring data include measurement of implementation and outcomes of protocols and adequacy of supplies and staffing.	0. There is no documentation that shows that the TB program is evaluated. 1. TB care and treatment is monitored and evaluated. (Refer to checklist) 2. A quarterly analysis of TB data is performed and a report written according to the guidelines. 3. Quarterly reports are submitted five days after the end of each quarter to HMIS.					

STANDARD #14: Anesthesia and sedation used appropriately

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies and procedures guide the pre-anesthesia and pre-sedation processes and the monitoring of the patient during the administration of general, regional and local anesthesia as well as during recovery.	0. There are no or incomplete policies, procedures and protocols for anesthesia. 1. Current evidence-based policies, procedures and protocols are developed for anesthesia/ sedation that include: a. Definitions of the different types of sedation provided b. Procedures and areas in which sedation is provided c. Screening for risk factors that may increase likelihood of adverse effects d. Evaluation before sedation e. Management during sedation (e.g. vital signs) f. Monitoring during recovery g. Criteria to return to unit 2 A multidisciplinary team from departments that provide anesthesia develop the policies and procedures collaboratively. 3 Staff participating in anesthesia is trained to implement the policies, procedures and protocols.					
Level 2. The policies, procedures, or protocols are consistently used for general, regional and local anesthesia, as applicable.	0. Anesthesia/sedation care is not consistently provided throughout the organization. 1. Staff interviewed is aware of the policies, procedures and protocols. 2. Anesthesia/sedation care is consistent wherever it is provided, e.g. endoscopy and surgery. 3. Documentation of anesthesia care is consistent and complete.					
Level 3. Data are collected on complications and incidents of anesthesia, and the data are used to improve anesthesia practices.	0. There are no data collected or reports regarding anesthesia complications or incidents. 1. Data regarding anesthesia complications and incidents is collected. 2. Anesthesia data is aggregated and analyzed and the results shared with clinical staff. 3. Improvements in anesthesia care are made based on the results of data.					

STANDARD # 15: Surgical services appropriate to patient needs

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies, procedures, or protocols are available for pre-operative patient assessments, monitoring patients during surgery, and the content of the surgical report.	0. The required surgical policies, procedures or protocols are not present and/or complete. 1. Policies, procedures or protocols are in place regarding: a. Conducting pre-op assessments; b. Recording a pre-op diagnosis; c. Monitoring patients during surgery; d. Operative report content and timely completion. 2. Policies, procedures and protocols are readily available to all relevant staff. 3. Relevant staff interviewed is aware of the policies, procedures and protocols.					
Level 2. The policies and procedures or protocols are consistently used for all types of surgical procedures and operative equipment is available and functioning.	0. Operative reports are not consistently completed according to policy and procedure. 1. The surgical safety checklist is implemented and documented in the medical record. 2 Functioning equipment is available for performing operative procedures. 3. In the majority of the records reviewed, the operative report includes at least the following: a. Start and end time of surgery; b. The procedure performed; c. Findings during surgery (intra-operative); d. Post-operative diagnosis; e. Surgical specimens removed (pathology); f. Name of surgeon and any assistants; g. Signature of the surgeon.					
Level 3. Data are collected on surgical complications and incidents, and the data are used to improve surgery safety.	0. There are no data collected or reports regarding surgical documentation. 1. Data regarding surgical complications are collected, including returns to surgery. 2. Surgical data are aggregated, analyzed and the results shared with clinical staff. 3. Improvements in surgical care are made based the data analysis and interpretation.					

STANDARD #16: Effective emergency triage

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Triage processes are described in policies and procedures.	0. No emergency triage policies and procedures are written. 1. Emergency triage policies and procedures are written for adult, pediatric and maternity patients. 2. The triage processes are based upon physiologic criteria. 3. Current evidence-based triage processes have been approved within the past 24 months.					
Level 2. Staff has been trained on use of the triage processes. The triage processes are implemented and documented within the medical record consistently.	0. Emergency triage is inconsistently implemented. 1. Relevant staff members are trained on how to perform triage of patients. 2. Staff members describe effective implementation of the emergency triage processes. 3. Documentation on the medical record shows that patients are prioritized according to relevant triage process.					
Level 3. Data are collected on the effectiveness of the triage processes.	0. No data are collected regarding the effectiveness of emergency triage. 1. Data are collected regarding the effectiveness of emergency triage, e.g. correct assignment of category based on criteria. 2. Data regarding emergency triage are aggregated, analyzed and results shared with clinical staff. 3. Improvements in emergency triage are made based on the data analysis and interpretation.					

STANDARD #17: Essential emergency equipment and supplies

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A list of essential emergency supplies, equipment and medications is developed based on the level of care and resuscitation provided by the hospital and populations served.	0. There is no list of essential emergency supplies, equipment and medications and/or some items on the list are not appropriate to the level of care provided. 1. A list of essential emergency equipment is developed that is based on the level of care and resuscitation provided by the hospital and populations served. 2. A list of essential emergency supplies is developed that is based on the level of care and resuscitation provided by the hospital and populations served. 3. The lists are reviewed/ updated on an annual basis or when service levels change.					
Level 2. The appropriate essential medications, supplies and equipment are available and well organized; equipment is in good working order and medications are within expiry date.	0. The emergency supplies and equipment are not well organized. 1. The emergency supplies and medications are observed to be organized, labeled and within expiry date. 2. The essential equipment is available and in good working order. 3. The process for managing emergency supplies and equipment is standardized throughout the organization.					
Level 3. The essential supplies, medications and equipment are monitored for availability and functioning.	0. The policy and procedure for ensuring the availability of supplies and functioning of equipment is not present and/or complete. 1. A policy and procedure outlines the process for maintenance of emergency supplies and equipment. 2. The inventory process for maintenance of emergency supplies and medications is carried out routinely and the stock is observed to be well secured. 3. Emergency equipment is included in the equipment maintenance program. *(**Note:** Check the emergency trolleys to determine whether they are organized in 1st line and 2nd line emergency drugs; and that the quantity is determined based on use.)*					

STANDARD #18: Ambulance services equipped

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies and procedures guide ambulance service delivery.	0. The required policies and procedures regarding ambulance services are not present. 1. Current policies and procedures are present and available to relevant staff that define: a. Who can use the service; b. Dispatcher and driver training; c. Equipment needed; d. Emergency procedures that can be performed and by whom; e. Maintenance of the vehicle and equipment; f. Mechanical and safety inspections; g. Process for receiving calls and dispatching ambulances; h. Cleaning and disinfecting of ambulances. 2. Interviews with relevant staff indicate that they are aware of the policies and procedures. 3. Ambulance register (book) is correctly and completely filled out according to the policy and procedure: a. Full name and the correct address of patients transported; b. The name of the clinical staff accompanying the ambulance; c. Name and signature of the responsible authorizing the departure; d. Name of the person who has called.					
Level 2. A check list is used to ensure that the contents of the ambulance are present, clean, functioning and within expiry date; staff operating within the ambulance are qualified.	0. The qualifications of ambulance staff is not included in their job descriptions. 1. Qualifications of the driver and staff members who assist in transport are described in their job description. 2. A check list is used daily to ensure that the contents of the ambulance are present, functioning and within expiry date. 3. Supplies and equipment are observed to be sufficient to carry out the emergency protocols. ***NOTE:*** *If the ambulance is not owned by the hospital, ask about the arrangement for transport and how the hospital ensures collaboration to transport patients and the quality of the service.*					
Level 3. The maintenance of the ambulance and effectiveness of the services is monitored.	0. The ambulance service mechanical inspection records are not reviewed by management at least quarterly. 1. The safety and mechanical inspection records are reviewed by management at least quarterly. 2. Data are collected regarding the effectiveness of the ambulance service (e.g. response time) and the monthly report of maintenance of ambulances of the hospital respecting PHECS format is submitted no later than 10th day of the month following the month reported. 3. The results of the data are used to develop action plans to improve the service.					

STANDARD #19: Safe Medication Use

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Medication use complies with national laws and regulations, e.g. narcotics management, and is overseen by qualified individuals.	0. The pharmacy is not supervised by a qualified pharmacist. 1. The personnel file includes documentation that the pharmacist in-charge is qualified according to local regulations. 2. There are policies and procedures that describe medication management processes within the hospital, which are consistent with laws/regulations, ministerial instructions and WHO guidelines, which include at least: a. Look-alike sound-alike drugs; b. Medication accuracy at transitions of care; c. Avoiding IV tubing disconnections; d. Who can prescribe medications; e. Who can administer medications; f. How medications are verified before administration; g. Storage of medications; h. How to manage high-alert medications, including concentrated electrolytes i. Narcotics and psychotropic drugs; j. Cold chain management. 3. Relevant staff interviewed is aware of the policies and procedures.					

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 2. The medication use policies and procedures are followed.	0. Medications are not consistently stored and dispensed in the pharmacy according to the policies and procedures. 1. Observation in the pharmacy demonstrates that medications are stored and dispensed according to policies and procedures. 2. Observation in the clinical areas demonstrates adherence to the management of medications and especially, high alert medications and narcotics management. a. Labeling and separation of high alert medications; b. Secured narcotics with records their management; c. Refrigerator temperatures maintained between the official limits; d. Absence of stock-out of essential drugs (based on the list adopted by the department). 3. Interviews with staff indicate that the cold chain is managed effectively. a. No interrupted cold chain during the past three months; b. Cold chain guaranteed in case of power failure (kerosene fridge with a kerosene stock of at least 5 liters, or a functioning generator: • Temperature of the fridge in the limits (between 2 degrees C and 8 degrees • pellet control of vaccine (PCV) in good condition					
Level 3. Monitoring data include medication errors and adverse events and are used to continually improve medication use.	0. There are no data regarding medication errors. 1. Adverse events and medication errors are identified and reported. 2. Data are collected, aggregated and analyzed regarding medication errors and adverse events. 3. Progress is evident toward implementing the Pharmacy & Therapeutic Committee's pharmaco-vigilance action plan, which contains interventions for reducing medication errors.					

STANDARD #20: Patients educated to participate in their care

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Policies and procedures describe the importance of patient education and the types of education that is given to all patients.	0. There are no policies and procedures regarding patient education. 1. The patient and family education policy and procedure includes: a. Assessment of patient and family educational needs; b. Providing education that meets patient and family ongoing health needs; c. Ways to evaluate the effectiveness of the education. 2. The policy and procedure describes the use of effective educational approaches, e.g. group, 1:1, use of verbal and written instructions and return demonstration. 3. Staff interviewed is aware of the policies and procedures.					
Level 2. Individualized patient education relevant to their condition is consistently provided and documented including medications, home management and follow-up care.	0. There is no evidence that physicians, nurses and other care providers participate in patient and family education. 1. Physicians, nurses and other health care providers participate in patient and family education. 2. Documentation indicates that patients and families participate in discharge planning 3. Individualized education is consistently provided during hospitalization and at discharge that includes at least (as needed): a. Safe use of medications; b. Safe use of medical equipment; c. Potential interactions between medications and food; d. Nutritional guidance; e. Pain management; f. Diagnostic test and rehabilitation techniques; g. Home self-management, e.g. wound care.					
Level 3. There is a process to evaluate the degree to which patients understood the education.	0. There is no evidence that patient and family education was effective. 1. Staff members interviewed describes their approaches to evaluating the effectiveness of patient and family education. 2. The majority of medical records have documentation that the patient and family understood the instructions. 3. The effectiveness of patient and family education approaches are evaluated and documented.					

STANDARD #21: Communication among those caring for the patient

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A current policy and procedure is in place that describes a standardized approach to providing information between caregivers that supports patient-centered care.	0. There are no policies and procedures regarding communication among caregivers. 1. A policy and procedure describes a standardized approach to hand-over communication between staff, change of shift and between different patient care units in the course of a patient transfer, e.g. SBAR (situation, background, assessment, recommendation) technique. 2. Write down and read back steps are included in the policy and procedure. 3. Staff interviewed indicates that all nurses are involved in change of shift reporting.					
Level 2. A standardized approach to hand-over communication is used between staff, change of shift and between different patient care units in the course of a patient transfer.	0. Staff are unaware of the hand-over technique. 1. Staff interviewed is knowledgeable about the techniques. 2. Pre-prepared hand-over report templates are provided to staff coming for the next shift, e.g., summary of daily report of meetings of staff (Refer to the reporting template) 3. The prepared reports are consistently completed based on the policy and procedure.					
Level 3. There is a process to assess the effectiveness of hand-over communications.	0. There is no process for assessing the effectiveness of hand-over communications. 1. Data is collected regarding the effectiveness of the hand-over process. 2. Data is aggregated and analyzed. 3. The results are used to improve the hand-over communication process.					

STANDARD #22: Referral/Transfer information communicated

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A policy and procedure is in place for transfer and referral of patients.	0. There is no policy and procedure for transfer and referral of patients. 1. A policy and procedure describes the transfer and referral processes. 2. The referral/transfer sheet includes: a. The reason for referral/transfer; b. Significant findings; c. Procedures and treatments; d. A list of current medications; e. The patient's immediate condition; f. Where the patient is being transferred; g. The type of transportation and required monitoring during transport. 3. Staff interviewed is aware of how to implement the policy and procedure.					
Level 2. Referrals/ transfers are timely and justifiable. The patient is referred to the appropriate healthcare specialist and facility to ensure continuity of care. Patients are transferred safely using the type of transportation and monitoring required.	0. The transfers/referrals are not justified in the medical record. 1. The transfers/referrals are justified in the medical record. 2. Documentation indicates that a copy of the referral/transfer sheet is sent with the patient when transferred to another facility. 3. A copy of the referral/transfer sheet is retained in 100% of the patient's record.					
Level 3. Data on referrals/ transfers are collected and used to continuously improve patient care and strengthen the referral system.	0. The majority of medical records reviewed do not include the type of transportation and monitoring required for patients being transferred. 1. Medical records reviewed indicate that patients are transferred using the type of transportation and monitoring required. 2. Data are collected regarding the numbers and types of transfers/referrals made. 3. Data are aggregated, analyzed and used to improve the referral system.					

STANDARD #23: Complete and thorough clinical documentation

		Score				
Look for:	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A current policy and procedure is in place that describes clinical documentation expectations.	0. There is no policy and procedure for clinical documentation. 1. A policy and procedure describes clinical documentation expectations. 2. The policy defines: a. Who is authorized to make entries in the medical record; b. How to make corrections in the record; c. Legibility; d. Dating and timing entries; e. Signatures and use of stamps; f. Use of approved abbreviations. 3. The policy includes expectations regarding the discharge summary contents.					
Level 2. The patient record is available to all those caring for a patient and the content is standardized and completed according to the policy and procedure.	0. A process for obtaining medical records during off hours is not evident. 1. A policy and procedure is implemented regarding obtaining medical records, particularly during hours when the central medical record department is closed. 2. All patient medical record entries are legible, complete, dated, and timed. 3. The discharge summary includes at least the following: a. The reason for admission; b. Significant findings, including investigations; c. Procedures performed; d. Diagnoses made; e. Medications or other treatments; f. Patient's condition at discharge; g. Follow-up instructions and all discharge medications that the patient is to take following discharge.					
Level 3. There is a process to review a quarterly, and this information is used to improve documentation in patient records.	0. Medical record reviews are not performed quarterly. 1. Staff interviewed describes the medical record review process. The process includes the following: a. Review of the completeness (content) and legibility of entries; b. A representative sample size from key services; c. Representative samples of all disciplines that make entries in the medical record. 2. Data are aggregated and analyzed. 3. Documentation shows that relevant staff members are provided feedback regarding the results.					

Risk area #5: IMPROVEMENT OF QUALITY AND SAFETY

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

STANDARD #1: Quality and safety program

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. A quality improvement focal person guides the quality and patient safety program; a quality and patient safety plan with terms of reference for the quality committee is written.	0. There is no QI focal person job description. 1. A current QI focal person job description is present. 2. There is a hospital wide plan for quality improvement and patient safety, which includes at least the following: a. A definition of quality; b. The description of quality improvement method used in the hospital; c. The membership of the quality improvement and patient safety committee and defines the leadership and responsibilities of the committee; d. The coordination among all components of the organization's quality improvement and safety activities; e. Hospital wide specific quality goals are identified; f. Quality and safety indicators that are currently being measured; 3. Each quality indicator has a clear definition, formula, data collection method, who is responsible for data collection, frequency of data collection, and target.					
Level 2. A quality focal person is coordinating the quality and patient safety activities. The quality plan has been implemented and progress toward meeting goals/objectives is tracked through the quality and patient safety committee.	0. There is no QI focal person and/or the focal person has not attended a formal QI course. 1. The QI focal person has attended a formal course in QI and patient safety approaches. 2. An interview with the QI committee indicates that the team is functioning. 3. Meeting minutes show that the goals/objectives of the quality plan are being tracked on a quarterly basis and indicators are reported and acted upon according to the plan. ***Note:*** *A formal course would consist of at least a 3-day workshop conducted by a qualified instructor.*					
Level 3. The quality and patient safety plan is evaluated annually and new goals/objectives and indicators set for the upcoming year.	0. The quality and patient safety plan is not evaluated annually. 1. Minutes of the QI Committee indicate that the quality and safety plan has been evaluated within the last 15 months. 2. Goals, objectives and indicators for improving quality and safety have been established for the current year. 3. The plan has been approved within the past 12 months.					

STANDARD #2: Effective customer care program

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is an effective customer care program.	0. There is no customer care program. 1. A customer care program defines the workplace expectations and performance guidelines for customer service. 2. A dress code is developed to present a professional image to the public that includes: a. Clothing; b. Shoes; c. Nail care; d. Jewelry; e. Hair. 3. A job description is written for the customer service representative and customer service expectations are included in all staff job descriptions.					
Level 2. The patient and family are treated with respect and dignity and individual needs are met.	0. The majority of staff has not been trained in customer care. 1. The majority of staff members have received general training regarding providing customer service and comply with dress code requirements. 2. Patients and their families are oriented to their environment upon outpatient visit and admission. 3. The customer care representative provides individualized assistance to address patient and family needs. ***Note:*** *Patient orientation includes such things as how to find their way, how to call for assistance, visiting hours, meals, and storing personal belongings).*					
Level 3. The effectiveness of the customer care program is monitored and actions taken to make improvements.	0. There is no monitoring of the effectiveness of the customer care program. 1. The customer care program is monitored through patient feedback (This may be done through the patient satisfaction survey or other means.). 2. Action plans are developed and implemented to improve the program. 3. Leadership describes how they provide recognition for good customer service behaviors.					

STANDARD #3: Patient satisfaction monitored

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is a policy, procedure and a tool to monitor patient satisfaction.	0. There is no policy, procedure or tool to monitor patient satisfaction. 1. A policy and procedure for monitoring patient satisfaction has been developed. 2. A tool has been developed and tested. 3. A sufficient sample size has been obtained for the targeted populations.					
Level 2. Patient satisfaction is monitored and the data analyzed according to the policy and procedure.	0. The leaders do not describe an effective patient satisfaction process. 1. Leaders describe an effective patient satisfaction survey process. 2. Data have been collected accurately (without missing data or mistakes in calculations). 3. Data have been aggregated, analyzed and displayed according to specific services/ departments.					
Level 3. Trends in patient satisfaction are used to set priorities for improvement or for further evaluation.	0. The data have not been used to make improvements. 1. An action plan has been developed to address priority issues identified. 2. Staff interviewed is aware of the patient satisfaction results and the actions being taken. 3. Minutes of meetings show that progress is being tracked.					

STANDARD #4: Complaint and suggestion process

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is a policy or procedure for receiving complaints and suggestions.	0. There is no policy and procedure regarding making oral or written complaints or suggestions or the process is not systematic. 1. There is a policy and procedure regarding making oral or written complaints or suggestions. 2. The leaders describe a standardized process for reviewing complaints. 3. The process is easily accessible to the public, e.g. pencils and paper available.					
Level 2. An effective process for reviewing and resolving complaints is operational. Feedback is given to individuals regarding how the issue was resolved, when possible.	0. Staff members are unable to describe how they advise patients regarding the complaint process. 1. Staff members are able to advise the patient and the family about the complaint management process. 2. Clinical staff members describe steps that they take to resolve patient complaints. 3. Staff members refer patients/families according to the policy when they are unable to resolve the patient/family issues.					
Level 3. Complaints and suggestions are categorized by type and tracked. This information is used to prioritize patient issues and implement solutions. The results of the solutions are monitored for effectiveness	0. Complaint data are not categorized and trended. 1. Data is aggregated, analyzed and trends identified. 2. Minutes show that complaints and suggestions are systematically reviewed within a committee. 3. Action plans are developed and implemented to correct recurring problems.					

STANDARD #5: Clinical outcomes are monitored.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Leadership identifies and defines priority clinical outcome indicators.	0. Indicators have not been established for key clinical outcomes. 1. Indicators have been established for key clinical outcomes including EIDSR, maternal, neonatal and child death, malaria death indicators), as established by hospital leadership. 2. Each indicator has a clear definition, formula, data collection method, who is responsible for data collection, frequency of data collection, and target. 3. Data are collected accurately and completely for each of the key clinical outcome indicators (including verbal autopsy for maternal and neonatal death).					
Level 2. Outcome data are compared to those of previous time periods and published benchmarks (if they exist) and to those of similar organizations (when data is available). Data is used by the facility staff to make improvements in care.	0. The majority of data for clinical outcome indicators are not aggregated and analyzed. 1. Clinical outcome data is aggregated and analyzed for each of the indicators. 2. The data are effectively displayed in graphs and charts. 3. The data are compared to established targets and trends over time.					
Level 3. The hospital systematically and proactively seeks outcome data from similar organizations and published benchmarks and compares its own performance.	0. The outcome data are not compared across hospital departments. 1. The data are compared across hospital departments. 2. The data are compared with other hospitals within the country. 3. Some indicator data are compared to published benchmarks, e.g. infection rates.					

STANDARD #6: Incident reporting system

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. Leaders are committed to an incident-reporting process. There is a policy and procedure for the reporting process that clearly defines the incidents to be reported.	0. There is no incident reporting policy and procedure. 1. An incident reporting policy and procedure identifies the events to be reported and how individuals affected are informed of the situation. 2. Sentinel events are defined and a process is in place for analyzing each sentinel event identified (root cause analysis). 3. Staff interviewed is aware of how to implement the policy and procedure.					
Level 2. The reporting process is implemented, and data are collected for incidents.	0. Few or no incidents have been reported. 1. Incident reports are submitted from each clinical department within the organization. 2. The incidents are categorized into types and severity of events, persons involved, and locations. 3. The report indicates that individuals affected by the incident are informed of the situation.					
Level 3. The data are analyzed and used to educate staff and to improve processes to avoid similar incidents from occurring.	0. The data are not aggregated, analyzed and displayed. 1. Data related to incident reporting are aggregated, analyzed and displayed. 2. Plans are made to reduce the potential for these events recurring. 3. The results of the interventions are tracked and actions taken accordingly (PDSA cycle).					

STANDARD #7: Staff demonstrate how to improve quality

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There are written priorities for staff quality and patient safety training.	0. No priorities have been set for quality and patient safety training. 1. A quality and patient safety training plan lists the priorities. 2. Priorities include training of hospital leaders and different levels of staff. 3. Priorities are based on current need to know information that supports implementation of the quality and patient safety program.					
Level 2. There is an organized training program for staff who participates in quality improvement and patient safety activities. Department QI teams are carrying out systematic quality improvement activities based on the PDSA model.	0. There is no quality and patient safety training program. 1. The quality and patient safety training program includes awareness and quality improvement methods. 2. The training activities are practical and interactive. 3. Training records indicate that the targeted groups attend the training activities.					
Level 3. The impact and effectiveness of the training program are documented and used to improve program content and scope over time.	0. The knowledge of trained staff members regarding quality and patient safety is not evaluated. 1. The knowledge of staff members attending quality training is evaluated. 2. The skills of staff attending quality training are evaluated. 3. The application of the skills to practice is evaluated.					

STANDARD #8: Communicating quality and safety information to staff

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. The usual means of communicating quality and safety information to staff is described in the quality plan.	0. The quality plan does not include expectations regarding when quality reports are to be submitted. 1. The quality plan identifies when the various departments/committees are to submit quality reports to the Quality Improvement Committee. 2. The plan identifies when and how information flows between the leadership, departments and staff. 3. Orientation records show that staff members are oriented to the quality plan.					
Level 2. Quality and patient safety information are regularly communicated to staff.	0. Quality and safety information are not consistently communicated to staff during staff meetings. 1. Staff meeting minutes show that quality and safety information is communicated monthly in some departments. 2. Staff meeting minutes show that quality and safety information is communicated monthly in the all of departments. 3. Staff interviewed was able to describe quality and safety activities performed within the department in the last 3 months.					
Level 3. Staff use of quality and patient safety information is evaluated to improve the effectiveness of the communication effort.	0. Meeting effectiveness is not evaluated quarterly in the majority of departments. 1. An evaluation of meeting effectiveness is conducted at least quarterly for all departmental staff meetings. 2. The results of the feedback are shared with each group. 3. An action plan is developed for each department to improve information sharing and use of quality information.					

STANDARD #9: Staff satisfaction monitored

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1. There is a policy, procedure and tool to monitor staff satisfaction.	0. There is no policy, procedure or tool to monitor staff satisfaction. 1. A policy and procedure for monitoring staff satisfaction has been developed. 2. A tool has been developed and tested. 3. A sufficient sample size has been obtained (at least 50% of all staff members).					
Level 2. Staff satisfaction is monitored according to the policy and procedure, and the data analyzed and reported to staff. An improvement plan is developed and implemented.	0. Staff satisfaction data have not been collected. 1. An annual hospital staff satisfaction survey is conducted. 2. Data have been collected accurately. 3. Data have been aggregated, analyzed and displayed according to specific services/ departments.					
Level 3. Trends in staff satisfaction are used to set priorities for improvement or for further evaluation.	0. The results of the staff satisfaction have not been shared with the staff. 1. Staff meeting minutes show that the outcomes of the survey are made known to staff. 2. An action plan has been developed to address priority issues identified. 3. The action plan has been implemented, progress is being tracked and the impact is measured.					

GLOSSARY

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

Term	Definition
Healthcare-associated infections	Infection originating in a health care facility
High risk	An uncertain event or condition, that if it occurs, potentially results in harm or death.
Identifiers	Names or labels associated to a person. The use of two patient identifiers improves the reliability of the patient identification process. Examples of acceptable patient identifiers include: name, assigned identification number, telephone number, date of birth, social security number, or address.
Incident	Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm, which includes errors, preventable adverse events, and hazards.
Leaders	In Rwandan hospitals, the use of this term refers to the Hospital Director, Clinical Director, Chief of Nursing, Hospital Administrator, Human Resources Manager
Leadership	In Rwandan hospitals, the use of this term refers to the leaders and managers.
Managers	In Rwandan hospitals, the use of this term refers to department heads and midwives/nurse in-charges
Majority	In this assessment tool, a simple majority is anything greater than 50%.
Nutritional care	Interventions and counseling to promote appropriate nutrition intake. This activity is based on nutrition assessment and information about food, other sources of nutrients, and meal preparation. It considers the patient's cultural background and socioeconomic status.
Patient safety	Prevention of errors and adverse effects to patients associated with health care.
Plan of care	A detailed method, formulated beforehand, that identifies needs, lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, policies and procedures, protocols, treatment guidelines, clinical paths (or care maps), or a combination of these.
Policy	A policy is a principle or rule to guide decisions and achieve rational outcomes. A policy is a statement of intent, and is implemented as a procedure.
Procedures	Procedures are step-by-step instructions on how to perform a technical skill. This format often involves the use of equipment, medication, or treatment.
Protocol	Care management plans that set out specifically what should be done, when and by whom in providing patient care. They are developed based on from recommendations outlined in clinical practice guidelines.
Qualifications	The education, training, experience, competence, registration, certification or applicable license, law or regulation of a healthcare worker.
Sentinel events	A sentinel event is an unanticipated occurrence involving death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.
Standards	A statement of expected quality, which can be presented in various formats (policies, procedures, protocols, standing orders, standard operating procedures, etc.)
Triage	A process of sorting patients in a healthcare facility to determine their priority for treatment.