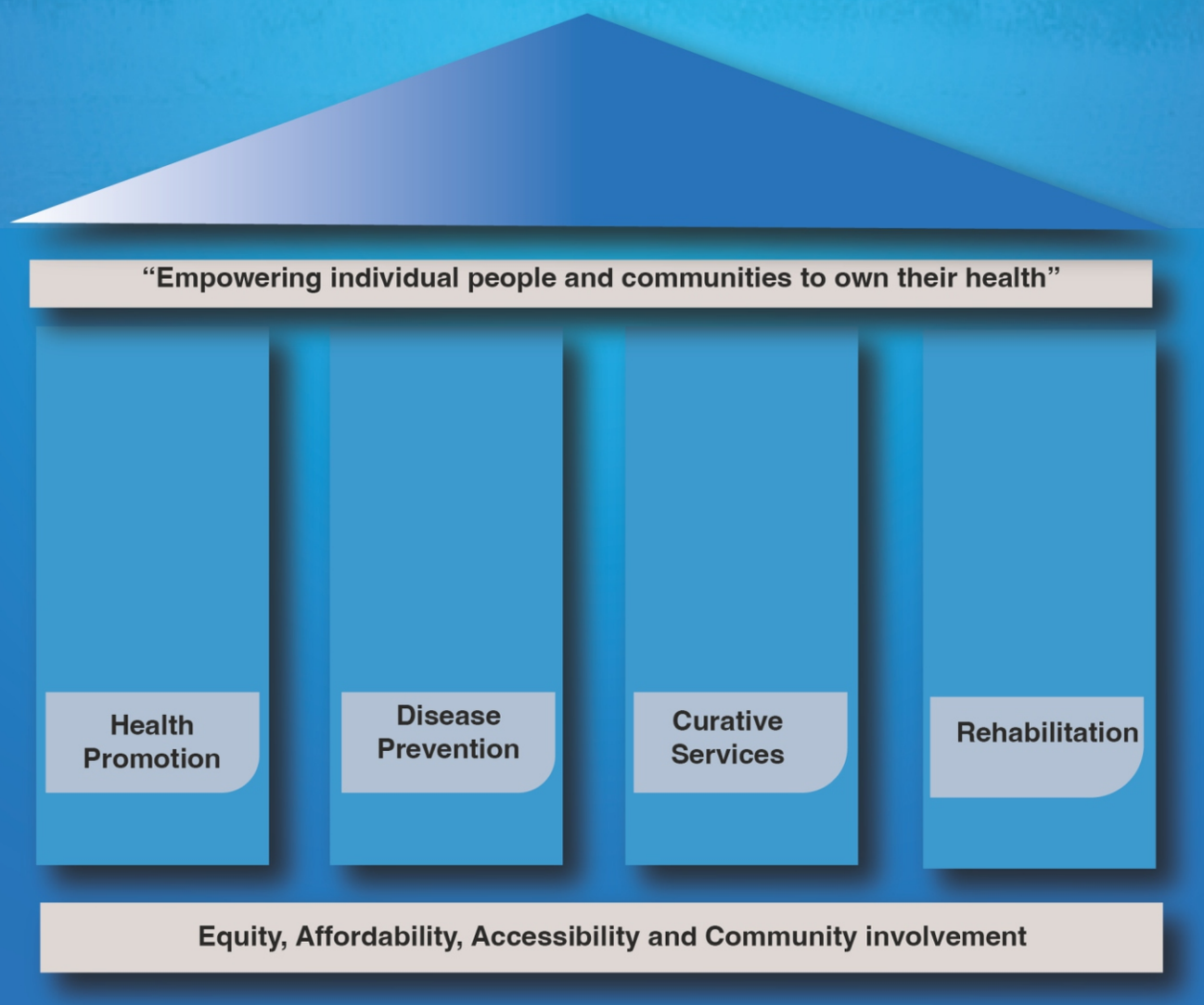
Republic of Namibia
Ministry of Health and Social Services



PRIMARY HEALTH CARE FACILITIES QUALITY STANDARDS

1st Edition I April 2021

Ministry of Health and Social Services

NAMIBIA

PRIMARY HEALTH CARE FACILITY STANDARDS

1st Edition
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A: FOREWORD

The new Namibian National Health Quality Standards for Hospitals and Primary Healthcare facilities were developed in collaboration with the healthcare facility personnel, clinicians, and an established South African healthcare accreditation organization. While the content of the standards has been chosen by people working at the implementation level and familiar with current best practices, the structure and organization of the standards meet the requirements of the International Society for Quality in Healthcare. The overarching aim of the standards is to improve the health outcomes and overall standard of healthcare delivery in the country.

All healthcare personnel must recognize their shared responsibility to facilitate seamless patient transitions along the continuum of care and to work together as a team and communicate with each other about the patients' care.

Standards will assist in identifying gaps in the healthcare system at all levels. They further include care coordination issues that affect patients throughout the continuum of care, for example, medication reconciliation, care transitions, patient engagement and education, environmental and equipment issues, data, supervision and support, personnel qualifications, policies and procedures, and communication.

Poorly coordinated care puts patients at risk for preventable events such as medication errors, lack of necessary follow-up care, and diagnostic delays and errors. These errors, delays, and care gaps can lead to repeat testing and procedures, a dissatisfying care experience, and preventable patient harm, including unnecessary hospital admissions/readmissions and mortality.

Compliance with the standards should demonstrate and achieve a positive impact on patient safety and health outcomes and will enable the implementation of an accurate measurement and evaluation system. Successful implementation of the standards will depend on the implementation of three main, interlinking factors: leadership and management, resources, and end-user-related factors.
Facilities that participate in the accreditation program must provide evidence that shows a continued commitment to provide the highest quality services. They will be periodically evaluated by the Ministry of Health and Social Services Quality Assurance Division and/or internationally recognized accreditation bodies for compliance with the standards and other requirements and are provided with advice and education from experts about quality improvement.

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

Although optimization of the physical environment is an important goal, excellent care can be provided with limited resources; proper training, personnel support, and functional administrative structures are the most important priorities. Accreditation can be within the grasp of all healthcare facilities since standards are intended to encourage compliance with current best practice.

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BEN NANGOMBE
EXECUTIVE DIRECTOR

B: GUIDE TO THE USE OF THE STANDARDS

The purpose of this section is to serve as a guide to surveyors/assessors and quality advisors, as well as healthcare facility personnel. It provides information on certain key aspects pertaining to the layout of the standards and their interpretation, as well as core principles to be applied in assessing standard compliance.

1. Structure/Format

The standards consist of several Service Elements (SEs) for the various functions required for the delivery of services. Each Service Element contains the relevant standards and criteria (measurable items) to be assessed in order to ascertain the level of compliance with the standards.

The first section of Service Element 1 for the Hospital Standards - *Management and Leadership* - is used as an example to demonstrate the layout of the standards:

1. Management and Leadership

Overview of Management and Leadership
Providing excellent patient care requires effective management and leadership at all levels in a hospital…..

Standards

1.1. Governance of the hospital

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

Standard Intent

The governance structure is responsible for directing the operation of the hospital and accountable for providing quality healthcare services to its catchment population…

Criteria

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

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

HEADINGS IN EXAMPLE ABOVE	EXPLANATION
1. MANAGEMENT AND LEADERSHIP:	The number and name of the Service Element.
Overview of Management and Leadership	General description of the Service Element and context of the standards in the Service Element.
1.1 Governance of the hospital	The first Performance Indicator (or main section) for this Service Element.
1.1.1 Governance responsibilities and accountabilities are described in legislation, policies and procedures or similar documents that show how these duties are to be carried out.	The first standard in this Service Element.
Standard Intent The governance structure is responsible for directing the operation of the hospital and accountable for providing quality healthcare services to its catchment population…	A description of the context/scope of the abovementioned Standard 1.1.1. Note that the information in this intent statement forms an integral part of aspects to be considered when measuring compliance of criteria.
Criteria	This heading indicates that what follows is the list of criteria (measurable items) that support the standard.
1.1.1.1 The hospital's governance structure is described in written documents and is known to the personnel of the hospital.	The first criterion in this section for Standard 1.1.1

2. Notes on the Standard Interpretation Guidelines

The guideline appears in a separate section (in italics) below the criterion as described above. It contains a description/explanation of what is expected and guidance on how to assess compliance with the criterion.

Criterion 5.1.1.6
Ongoing in-service training of all personnel in these policies, procedures and risk management principles, including reporting of adverse events, is documented.

A record must be kept of such training, with analysis to show the percentage of personnel trained in each department. A training schedule should also be available to demonstrate the training sessions to be offered to provide ongoing training.

The purpose of these guidelines is to provide guidance on the scope and interpretation of the criterion statement. The information should also provide facility personnel with a clear indication of the requirements for compliance and some direction on the surveyors/assessors' approach when assessing the evidence of compliance.

3. Definitions of Severity Ratings allocated to criteria

Criteria for evaluating the seriousness of non-compliance with standards:

Mild (1) Safety of personnel and patients may be placed at some degree of risk with the possibility that non-compliance could lead to reduced performance and litigation.

Moderate (2) Seriously affects the health of the patients, the personnel and the financial functioning of the institution, with a probable reduction in efficiency and personnel satisfaction, which could lead to litigation.

Serious (3) Shortage of appropriate suitably qualified personnel and safe facilities, which will hamper service delivery and personnel satisfaction and could lead to litigation.

Very Serious (4) Patients and personnel are at high risk of death or severe morbidity due to limited or substandard service delivery or prevailing conditions, which are unsafe or illegal.

4. Definitions of Categories allocated to criteria

1. Criteria for evaluating the seriousness of non-compliance to standards:

CATEGORY	SERIOUSNESS	CRITERIA
1. Patient and staff safety	1. Mild	Safety of patients, communities and personnel may be placed at some degree of risk in combination with other factors.
	2. Moderate	Safety of patients, communities and personnel may be placed at some degree of risk.
	3. Serious	Dangerous: patients, communities and personnel are likely to be put into serious danger.
	4. Very serious	Extremely dangerous: patients, communities and personnel will be put into immediate and serious danger, for example, through contaminated food, faulty electricity, structure or equipment.

2. Legality	1. Mild	In contravention of some policies but unavoidable under the circumstances and accepted by personnel, although not ideal.
	2. Moderate	Possibility that non- or partial compliance may lead to litigation or negative press reports.
	3. Serious	Strong likelihood that noncompliance will lead to litigation.
	4. Very serious	In direct contravention of current applicable acts and regulations.
3. Patient Care	1. Mild	Patients may suffer some discomfort, but the situation is accepted by staff and patients as being unavoidable under the circumstances
	2. Moderate	Patients will not receive optimal care, but care provided will be within safe limits
	3. Serious	Patients at risk of receiving minimal or substandard care, for example, lack of adequate numbers of appropriate suitable qualified personnel
	4. Very serious	Patients are at risk of death or severe morbidity due to limited or substandard care or the prevailing circumstances are such that they will receive limited or no care

4. Efficiency	1. Mild	Planning required to achieve optimal efficiency with emphasis on management and clinical inservice training.
	2. Moderate	Lack of communication, participative management or inadequate budgeting lead to reduced efficiency.
	3. Serious	Seriously affects the personnel and financial functioning of the institution with probable personnel dissatisfaction and lowered morale. Intervention required with particular emphasis on education and training.
	4. Very serious	Has a major effect on financial liability and on the ability of personnel to perform their duties. Immediate intervention is required.
5. Structure	1. Mild	Maintenance is required to preserve buildings and improve aesthetics of physical structure.
	2. Moderate	Facilities unsightly and cramped. Upgrading required in the near future.
	3. Serious	Shortage of suitable, safe facilities will impair service delivery and personnel satisfaction. Upgrading of facilities required as soon as possible.
	4. Very serious	The structure will be totally unsuitable for the provision of a safe and effective service. New facilities and/or upgrading of existing facilities urgently required.

5. Rules for assessment of compliance with criteria and the scoring system

Standards are written expectations of structures, processes or performance and it is assumed that if standards are met, better care can be delivered. If standards are substantially met, a

facility can achieve certification/accreditation. The standards, in turn, are defined by objective, measurable items called criteria. Weighted values are allocated to each criterion according to the importance of the criterion in relation to medicolegal requirements and the impact of non- or partial compliance on safe patient care. This is the "severity rating" and, for the scoring system linked to this document, criteria are rated from 1 (mild) to 4 (very serious).

Take note that assessing compliance with the standards and criteria includes various activities such as studying documentation, personnel and patient interviews, auditing of patient records, and observation of service delivery, physical facilities and equipment.

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

5.1 ***Compliant (C)*** means the condition required is met. Evidence of compliance should be present in a tangible and/or observable form, for example, documented material, physical items, etc.

5.1.1 For example, should the standards require a **documented** process, but the facility has only a verbal process in place, then the criterion should be scored as ***noncompliant***.

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

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

5.2. ***Partially compliant (PC)*** means the condition required is not totally met, but there is definite progress towards compliance *and the deficiency does not seriously compromise the standard.* Other considerations for PC ratings are:

5.2.1 If the criterion requires a documented process as listed above but there is no implementation or implementation is partial or if the process document is still in draft form.

5.2.2 If the criterion contains more than one requirement, for example, "There is an organisational chart or document that describes the lines of authority and accountability between the governance structure and the healthcare facility, as well as within the facility" but not all components are compliant.

5.2.3 If assessment results can be quantified by means of conducting an audit, for example, "less than 80% of personnel have received training". In this case, achievement of less than 40% quantifiable compliance will be awarded a noncompliant score, between 40% and 80% will be awarded a partially compliant score and achievement of greater than 80% compliance will be awarded a fully compliant score. This is known as the 40/80 rule of compliance.

5.3. ***Non-compliant (NC)*** means there is no observable progress towards complying with the criterion requirement.

5.4. ***Not applicable (NA)*** means the criterion will not be scored because the service is either not provided at all, or not provided at the particular level the criterion is designed to measure. Such criteria are excluded in calculating compliance scores.

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

Rating	**Score**
C	100
PC mild	75
PC moderate	65
PC serious	55
PC very serious	45
NC mild	35
NC moderate	25
NC serious	15
NC very serious	5
NA	Not scored

Aggregating and averaging criterion scores calculates the level of compliance of standards. A non-compliant criterion that is very serious will subtract almost the entire numerical contribution to the score, whereas a mild non-compliant criterion will subtract less from the score. All standards are deemed equally important and therefore allocated equal weighting.

6. Critical criteria

A standard may have one or more criteria that are marked “critical”. Non- or partial compliance with these requirements will compromise patient or personnel safety, or represent legal transgressions. Critical criteria that are non- or partially compliant are incompatible with accreditation.

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

Where a critical criterion is scored as PC, but it is so serious as to constitute a danger to patient and/or personnel safety, is in direct contravention legislation, severely affects service delivery or the efficiency of the facility, then it must be scored as NC, for example, there is a fire alarm, but it is not working. This must then be scored as NC rather than PC.

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

C: ADDITIONAL COMMENTS

1. Several criteria require compliance with country-specific legislation. In instances where such legislation does not exist for such an item, it will be expected that the facility will develop their own internal process in accordance with internationally accepted norms and standards.

2. Any reference to personnel in the standards and criteria should be interpreted to read all personnel employed by the facility unless otherwise stated. The requirements also apply to all employees who are allowed to render services within the facility (clinical and non-clinical), regardless of their employment status.

3. Many criteria require documented/recorded evidence. This can be provided either as paper copies of the documents or in electronic format. If provided in electronic format, surveyors must be given access to the relevant folders and files. This may include the information being provided on a data stick, or access to the facility's computer system.

4. The use of the words "must" and "should" in the standard respectively denotes requirements which are non-negotiable in terms of legal compliance, critical criteria or patient safety requirements (indicated by the use of "must") or requirements specified by the standards but not mandatory for accreditation ("should").

5. Criteria to be measured by means of documentation assessment are indicated as such in the guideline by means of the following statement: "Documented evidence required". The criterion statements, standard intent statements or guideline should clarify the type of documentation required, for example, documented processes, evidence of monitoring of implementation of the process, training records, qualifications of personnel, etc.

D: INTERPRETATION OF TERMS USED IN THE STANDARD ASSESSMENT MANUAL

Acceptability	Acknowledgement that the reasonable expectations of the patient, funders and the community have been satisfied.
Access control	This refers to the process by which entrance to particular areas in the facility is restricted. This can be restricted to authorised persons only, for example, kitchen personnel, theatre personnel, etc.; or it can refer to the practice whereby entrance to a particular ward is controlled, for example, the requirement for visitors to the maternity or paediatric wards to be permitted entry on an individual basis. The latter can be achieved by means of physical barriers, for example, locked doors, or functional barriers, for example, a requirement to sign in or out of the ward under observation of a security guard or ward clerk, or a vigilant security guard observing the arrival and departure of visitors to the ward.
Accessibility	Means that access to healthcare services is unrestricted by geographic, economic, social, cultural, organisational or linguistic barriers.
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Accreditation	A determination by an accrediting body that an eligible healthcare facility is in compliance with applicable predetermined standards. (See also *certification, licensure.)*
Accreditation survey	An external evaluation of a healthcare facility to assess its level of compliance with standards and to make determinations regarding its accreditation status. The survey includes evaluation of documentation provided by personnel as evidence of compliance; verbal information concerning the implementation of standards, or examples of their implementation, that will enable a determination of compliance to be made; and onsite observations by surveyors.
Adverse event	An **adverse event** may be defined as any event or circumstance arising during a stay in facility that leads to unintended or unexpected physical or psychological injury, disease, suffering, disability or death not related to the natural cause of the patient's illness, underlying condition or treatment. A **near-miss** is defined as any event or situation that had the potential to cause harm to a patient in the form of an accident, injury or illness, but did not, either by chance or through timely intervention. A **sentinel event** is an unexpected occurrence (as it is not related to the natural course of the patient's illness or underlying condition) involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence carries a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response. Sentinel event reporting can be a useful quality and patient safety improvement tool. *Joint Commission International*

Advocacy	Representation of individuals who cannot act on their own behalf and/or promoting individual rights and access to the resources that will allow them to fulfil their responsibilities.
Ambulatory care	Healthcare services that do not require the hospitalisation of a patient, such as those delivered at a physician's office, clinic, emergency unit or outpatient department.
Analysis of data	This is the process of applying logical or statistical techniques to the collected raw data to describe, condense and evaluate the content of the collected data. The purpose is to turn the raw data into useful information (see below) that can be used for the identification of themes or trends, for example, limitations in the procurement processes resulting in multiple adverse events throughout the facility due to lack of supplies; and for planning purposes, for example, a steady increase of diabetic patients indicating the need to provide additional diabetic clinics and personnel.
Appraisal system	The evaluation of the performance of individuals or groups by colleagues using established criteria.
Appropriateness	The extent to which a particular procedure, treatment, test or service is effective, clearly indicated, not excessive, adequate in quantity and provided in the setting best suited to the patient's needs.
Assessment	Process by which the characteristics and needs of patients, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action.
Audit	1. Systematic inspection of records or accounts by an external party to verify their accuracy and completeness. 2. Periodic in-depth review of key aspects of the facility's operations. An audit provides management with timely information about specific topics and/or the cost-effectiveness of operations, addressing both quality and resource management issues. 3. In performance measurement, regular systematic, focused inspections by an external party of facility records and data management processes to ensure the accuracy and completeness of performance data. 4. See also *clinical audit.*
Benchmarking	A method of improving processes by studying the processes of organisations that have achieved outstanding results and adapting these processes to fit the particular needs and capabilities of the healthcare facility concerned.
Biologicals	Medicines made from living organisms and their products including, for example, serums, vaccines, antigens and antitoxins.

Biohazard	Biohazards are infectious agents or hazardous biological materials that present a risk or potential risk to the health of humans, animals or the environment. The risk can be direct through infection or indirect through damage to the environment. Biohazardous materials include certain types of recombinant DNA; organisms and viruses infectious to humans, animals or plants, for example, parasites, viruses, bacteria, fungi, prions, rickettsia; and biologically active agents, i.e. toxins, allergens, venoms; that may cause disease in other living organisms or cause significant impact to the environment or community. Biological materials not generally considered to be biohazardous may be designated as biohazardous materials by regulations and guidelines.
Business plan	A plan of how to achieve the mission of the facility. The plan includes financial, personnel and other sub-plans, as well as service development and a quality strategy.
Cardiopulmonary resuscitation (CPR)	The administration of artificial heart and/or lung action in the event of cardiac and/or respiratory arrest. The two major components of cardiopulmonary resuscitation are artificial ventilation and closedchest cardiac massage.
Caregiver	Anyone who regularly and, in an unpaid capacity, helps a relative or friend with domestic, physical or personal care required by virtue of illness or disability.
Certification	The procedure and action by which a duly authorised body evaluates and recognises (certifies) an individual, institution or programme as meeting predetermined requirements, such as standards. Certification differs from accreditation in that certification can be applied to individuals, for example a medical specialist, whereas accreditation is applied only to institutions or programmes, for example, a facility or a training programme. Certification programmes may be non-governmental or governmental and do not exclude the uncertified from practice, as do licensure programmes. While licensing is meant to establish the minimum competence required to protect public health, safety and welfare, certification enables the public to identify those practitioners who have met a standard of training and experience that is set above the level required for licensure.
Clinic	1. A defined healthcare session in a healthcare setting. 2. A defined healthcare setting.
Clinical audit	A clinically led initiative that seeks to improve the quality and outcome of patient care through structured peer review, in terms of which clinical personnel examine their practices and results against agreed standards and modify their practice where indicated.
Clinical personnel	All healthcare workers who are registered/enrolled with a professional body and involved in the care of patients in a particular setting. (See also *health professionals.)*
Clinical practice guideline	A generally accepted principle for patient management based on the most current scientific findings, clinical expertise and community standards of practice.

Clinical practice pathway	The optimal sequence and timing of interventions by physicians, nurses and other disciplines for a particular diagnosis or procedure, designed to minimise delays and resource utilisation and to maximise the quality of care. Clinical pathways differ from practice guidelines, protocols and algorithms as they are used by a multidisciplinary team and focus on quality and coordination of care.
Clinician	Refers to a person registered as a medical doctor or a nurse.
Clinical privileges	Authorisation granted by the governing body to clinical personnel to provide specific patient care services in the facility within defined limits, based on an individual practitioner's registration, education, training, experience, competence, health status and judgement. (See also *privileging*.)
Community	A collective of individuals, families, groups and organisations that interact with one another, cooperate in common activities, solve mutual concerns, usually in a geographic locality or environment.
Complementary therapist	Any practitioner who offers an alternative therapy to orthodox medical treatment. Complementary medicine does not replace conventional medicine.
Compliance	To act in accordance with predetermined requirements, such as standards.
Confidentiality	The assurance of limits on the use and dissemination of information collected from individuals.
Contaminated blood supplies	1. Any blood supply that was issued to a patient after cross matching but was not used. 2. Any blood that was not transfused and is left in the bag. 3. The empty bags after a blood transfusion.
Continuity	The provision of coordinated services within and across programmes and organisations, and during the transition between levels of services, across the continuum, over time, without interruption, cessation or duplication of diagnosis or treatment.
Continuum	The cycle of treatment and care incorporating access, entry, assessment, care planning, implementation of treatment and care, evaluation and community management.
Continuing education	1. Activities designed to extend knowledge to prepare for specialisation and career advancement and to facilitate personal development. 2. Education beyond initial professional preparation that is relevant to the type of service delivered by the facility that provides current knowledge relevant to the individual's field of practice, and that is related to findings from quality improvement activities.
Contract administration	Written agreements and the administration thereof between the purchaser of the service (the facility) and the provider of the service (the external company).

Contracted service	A service that is obtained by the facility through a contract with an agency or business. The contracted service should be monitored and coordinated by facility personnel and comply with national regulations and facility policies.
Controlled medication	This refers to medication identified by legislation as requiring particular, stringent conditions of storage, dispensing and administration. Such medication can be referred to as scheduled drugs or dangerous drugs. Such medication commonly includes opioids, hypnotics, barbiturates, etc. Country-specific legislation will apply.
Credentialing	The process of obtaining and reviewing the clinical training, experience, certification and registration of a healthcare professional to ensure that competence is maintained and consistent with privileges.
Criterion	A descriptive statement that is measurable and reflects the intent of a standard in terms of performance, behaviour, circumstances or clinical status. A number of criteria may be developed for each standard.
Data	Unorganised facts from which information can be generated.
(a) Longitudinal data	Implies that the data has been collected over a given time span.
(b) Comparative data	When a data set is compared with like data sets from other healthcare organisations; or from the same organisation at another time, usually of the previous month or year.
Data retention	Guidelines on how long a facility should keep information on various media.
Delegation	Act or function for which the responsibility has been assigned to a particular person or group. The ultimate accountability for the act remains with the original delegating person or group.
Discharge note	The discharge note, which may be completed by the nursing personnel, provides the patient and the patient's carers with written follow-up instructions, including medication, any specific dietary and medical orders and when to return for follow-up treatment, or where the patient must go to obtain further treatment.
Discharge summary	Follow-up instructions recorded in writing in the patient's record by the medical practitioner. The discharge summary must include: • The diagnosis of main and significant illnesses • The results of investigations that will influence further management • All procedures performed • The patient's condition at discharge • Discharge medication • Follow-up arrangements where appropriate, including emergency review
Effectiveness	Successfully achieving or attaining results (outcomes), goals or objectives.

Efficiency	Refers to how well resources (inputs) are brought together to achieve results (outcomes) with minimal expenditure.
Element, generic	An organisational system within a service element that must achieve and maintain the stated standards and criteria in order for the service element to function optimally.
Element, service	Organisational unit of the facility or personnel with a director, manager or other designated person in charge. May be a professional service, such as nursing or surgery; a professional support service, for example, radiology, physiotherapy; a general support system such as administration or health record system; a committee to guide aspects of the service, for example, health and safety; or a community health service.
Endemic disease	A physical or mental disorder caused by health conditions constantly present within a community, for example, malaria, influenza, depression, etc. *(Mosby's Medical Dictionary, 8th Edition 2009.)*
Ethics	Standards of conduct that are morally correct.
Evaluation	1. The process of determining the extent to which goals and objectives have been achieved. Actual performance or quality is compared with standards in order to provide a feedback mechanism that will facilitate continuing improvement. 2. For the purposes of accreditation, an assessment of the performance of a healthcare facility based on accreditation standards, without or before rendering an accreditation decision. The results of the assessment can be used to determine an accreditation decision or simply be made available to the subject organisation or a requesting third party. The evaluation may be identical to an accreditation survey or may be customised to meet the requester's needs.
Facility	The health centre, general practice, or any other site providing a health service.
Flammable	Capable of being set on fire and of burning quickly.
Framework	A basic structure underlying a system, for example, the framework of documented processes of the facility provides the foundation for the delivery of services according to the values of the facility to achieve its mission.
Function	A goal-directed, interrelated series of processes, such as patient assessment, patient care and improving the organisation of care.
Governance	The function of determining the facility's direction, setting objectives and developing policy to guide the facility in achieving its mission.
Governing body	Individuals, group or agency with ultimate authority and accountability for the overall strategic directions and modes of operation of the facility, also known as the council, board, etc.
Guidelines	Principles guiding or directing action.

Handover	The process of passing patient-specific information from one caregiver to another, from one team of caregivers to the next, or from caregivers to the patient and family for the purpose of ensuring patient care continuity and safety (JCI).
Hazardous material	Material that will endanger life or the environment if released without necessary precautions being taken, for example, radioactive, flammable, explosive, or poisonous material.
Health	A state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity.
Health professionals	Medical, nursing or therapeutic support personnel who provide clinical treatment and care to patients, having membership of the appropriate professional body and, where required, having completed and maintained registration or certification from a statutory authority. (See also *clinical personnel.*)
Health promotion	Process that enables people to increase control over and improve their health (World Health Organisation, 1986).
Health record	Compilation of pertinent facts of a patient's life and health history, including past and present needs and interventions, written by team members contributing to the care and treatment of the patient.
Healthcare waste	Healthcare waste (HCW) is a by-product of health care that includes sharps, non-sharps, blood, body parts, chemicals, pharmaceuticals, medical devices and radioactive materials.
High risk	Refers to aspects of service delivery which, if incorrect, will place patients at risk or deprive them of substantial benefit.
High volume	Refers to aspects of service delivery that occur frequently or affect large numbers of patients.
Human resource planning	Process designed to ensure that the personnel requirements of the facility will be constantly and appropriately met. Such planning is accomplished through the analysis of internal factors such as current and expected skill requirements, vacancies, service expansions and reductions, and factors in the external environment such as the labour market.
Health summary	A 'health summary' is written by the medical practitioner assisted by the nurse in charge of the medical record. It can be read once the patient has been discharged and revisits the same facility. The health summary will quickly and accurately inform the personnel at the facility of the condition and treatment the patient received at the previous visit.
Healthcare associated infections	Infections occurring after exposure to health care, often, but not always, as a consequence of this exposure (ECDC).
Implementation	The delivery of planned health care.
Integrity of data	Relates to the completeness and accuracy of a set of data required to fulfil a particular information need. This data is protected from unauthorised additions, alterations or deletions.

Incident plan, external	A plan that defines the role of the facility in the event of a major national or local disaster that may affect the health of many people. The plan must be developed in participation with the relevant local authority, police, civil defence, fire brigade and ambulance teams.
Incident plan, internal	A plan that provides details of preparation for action in the event of a disaster within the facility that affects the health or safety of patients and personnel, such as fire, bomb threats, explosions, loss of vital services.
Incidents	Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on patients, groups, personnel or the facility.
Indicator	1. A measure used to determine and monitor performance of functions, systems or processes over time. 2. A statistical value that provides an indication of the condition, direction or performance of a defined process or achievement of a defined outcome over time. 3. The measurement of a specific activity that is being carried out in a healthcare setting, for example, weight for age is a measurement of a child's nutritional status.
Induction programme	Learning activities designed to enable newly appointed personnel to function effectively in a new position.
Information	Data that is organised, interpreted and used. Information may be in written, audio, video or photographic form.
Information management	Planning, organising and controlling data. Information management is a facility-wide function that includes clinical, financial and administrative databases. The management of information applies to computer-based and manual systems.
Informed consent	Informed consent is a process whereby a patient is provided with the necessary information/education to enable him/her to evaluate a procedure with due consideration of all the relevant facts. This will enable the patient to make an appropriate decision when determining whether to consent to or refuse the proposed treatment. The patient or legal representative should be informed about the patient's condition in as much detail as possible and in simple, non-medical language. The proposed service should be described and, if an invasive procedure is envisaged, it should be clearly explained. Facility personnel must confirm that the patient or legal representative has understood every detail. Should the procedure or treatment have risks or side-effects, these should be described, making sure they are understood. In the same way, the benefits and possible outcomes should be discussed. Alternative treatments should be offered and discussed. If the patient or legal representative should refuse the procedure/treatment, the consequences of such decision should be made clear and, if a second opinion is sought, the patient or legal representative should be informed of the consequences of the delay and assisted to obtain a second opinion.

Information system	Network of steps to collect and transform data into information that supports decision-making.
In-service training	Organised education designed to enhance the skills of the facility's personnel members or teach them new skills relevant to their responsibilities and disciplines.
Leadership	The ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people, and motivating and inspiring people to overcome obstacles.
Licensing	The process whereby a government authority grants a healthcare facility permission to operate following an onsite inspection to determine whether minimum health and safety standards have been met.
Management	Setting targets or goals for the future through planning and budgeting, establishing processes for achieving targets and allocating resources to accomplish plans. Ensuring that plans are achieved by the facility, staffing, controlling and problem-solving.
a) Senior/central management	This refers to the overall management team of the facility, for example, CEO, facility manager, financial manager, HR manager, etc.
b) Departmental management	This refers to the management team comprising departmental managers, for example, paediatric services management, medical services management, theatre services management, etc.
c) Service management	This refers to the management team responsible for managing cross-cutting services in the facility, such as resuscitation management, infection control management, risk management, etc. In some facilities, the same team may be responsible for several management functions.
Mechanism	The mode of operation of a process or a system of mutually adapted parts working together.
Mission statement	A statement that captures a facility's purpose, patient orientation and business philosophy.
Monitoring	A process of recording observations of some form of activity.
Monitoring and evaluation and improvement	A process designed to help facilities use their quality assessment resources effectively by focusing on high priority, quality-of-care issues. The process includes identifying the most important aspects of the care the facility (or department/service) provides, using indicators to systematically monitor these aspects of care; evaluating the care at least when thresholds are approached or reached to identify opportunities for improvement or problems; taking action(s) to improve care or solve problems; evaluating the effectiveness of those actions; and communicating findings through established channels.
Multidisciplinary	The combination of several disciplines working towards a common goal.

Multidisciplinary team	A number of people from several disciplines with complementary skills whose functions are interdependent. They work together for a common purpose or result (outcome) on a short-term or permanent basis. Examples include project, problem-solving, quality improvement and self-managed teams. For instance, the management team and quality improvement steering committees are multidisciplinary teams.
Objective	A target that must be reached if the facility is to achieve its goals. It is the translation of the goals into specific, concrete terms against which results can be measured.
Organisation	Comprises all sites/locations under the governance of and accountable to the governing body/owners.
Organisational chart	A graphic representation of responsibility, relationships and formal lines of communication within the facility.
Orientation programme	1. Activities designed to introduce new personnel to the work environment. 2. The process by which an individual becomes familiar with all aspects of the work environment and responsibilities, or the process by which individuals, families, and/or communities become familiar with the services and programmes offered by the facility.
Outcome	Refers to the results of the health care provided, expressed in terms of the patient's health status or physical or social function.
Peer review	The systematic, critical analysis of care, including the procedures used, treatment provided, the use of resources, and the resulting outcome and quality of life for the patient, with a view to improving the quality of patient care, by a group of persons of the same professional background.
Performance appraisal	The continuous process by which a manager and a personnel member review the personnel member's performance, set performance goals, and evaluate progress towards these goals.
Performance measure	A quantitative tool or instrument that provides an indication of the facility's performance regarding a specified process or outcome.
Plan	A detailed proposal describing the manner in which a particular goal will be achieved. 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, practice guidelines, clinical paths, care maps, or a combination of these. (JCI)
Planning	The determination of priorities, expected outcomes and health interventions.
Planning, operational	Determining ways in which goals and objectives can be achieved.
Planning, project	The art of directing and coordinating human and material resources throughout the life of a project by using modern management techniques in order to achieve predetermined objectives of scope, quality, time and cost, and participant satisfaction.

Planning, strategic	Determining a facility's mission and determining appropriate goals and objectives to implement the mission.
Position description	Details of accountability, responsibility, formal lines of communication, principal duties and entitlements. It is a guide for an individual in a specific position within a facility. This document may have different names; however, for the purposes of the accreditation standards, whichever document fulfils this function will be assessed for relevant criteria.
Practice	Partners in a professional practice, employed personnel and their patients.
Primary Health Care	The first level of contact of individuals, the family and community with the health system, bringing health care as close as possible to where people live and work. Primary health care includes health education, promotion of proper nutrition, maternal and child health care (including family planning), immunisation against the major infectious diseases, appropriate treatment of common diseases and injuries and the provision of essential drugs.
Privileging	Delineation for each member of the clinical personnel of the specific surgical or diagnostic procedures that may be performed and the types of illness that may be managed independently or under supervision.
Procedure	A mode of action. A procedure outlines the detailed steps required to implement a documented process.
Process	A sequence of steps through which inputs (from healthcare facilities) are converted into outputs (for patients).
Professional registration	Registration in terms of current legislation pertaining to the profession concerned.
Professional personnel	Personnel who have a college or university level of education, and/or who may require licensure, registration or certification from a provincial or state authority in order to practise, and/or personnel who exercise independent judgment in decisions affecting the service delivered to patients.
Professional team	A number of healthcare professionals whose functions are interdependent. They work together for the care and treatment of a specific patient or group of patients.
Programme	A set of related activities to be implemented with the goal of achieving a particular long-term aim, for example, the infection control programme will be constituted by all activities intended to reduce the incidence of healthcare-acquired infections at the facility. All such activities should be documented to ensure consistency and continuity of these activities.
Protocol	A formal statement. May include documented processes, policies, procedures or guidelines.
Quality	Degree of excellence, extent to which a facility meets patients' needs and exceeds their expectations.

Quality activities	Activities that measure performance, identify opportunities for improvement in the delivery of services and include action and follow-up.
Quality assurance	The monitoring of output to confirm that it conforms to specifications or requirements and action taken to rectify the output where necessary. It ensures safety, transfer of accurate information, accuracy of procedures and reproducibility.
Quality improvement	The actions undertaken throughout the facility to increase the effectiveness and efficiency of activities and processes, in order to bring additional benefits to both the facility and its patients.
Quality improvement programme	1. A planned, systematic use of selected evaluation tools designed to measure and assess the structure, process and/or outcome of practice against established standards and to institute appropriate action to achieve and maintain quality. 2. A systematic process for closing the gap between actual performance and desirable outcomes. 3. Continuous quality improvement is a management method that seeks to develop the facility in an orderly and planned fashion, using participative management, and has at its core the examination of process.
Recruitment and retention	The process used to attract, hire and retain qualified personnel. Retention strategies may include reward and recognition programmes.
Rehabilitation	A dynamic process that allows disabled people to function in their environment at an optimal level. This requires comprehensively planned care and service for the total person.
Reliability	The ability of an indicator to identify accurately and consistently the events it was designed to identify across multiple healthcare settings.
Research	Critical and exhaustive investigation of a theory or contribution to an existing body of knowledge aimed at the discovery and interpretation of facts.
Responsibility	The obligation that an individual assumes when undertaking delegated functions. The individual who authorises the delegated function retains accountability.
Risk	Exposure to any event that may jeopardise the patient, personnel member, physician, volunteer, reputation, net income, property or liability of the facility.
Risk management	A systematic process of identifying, assessing and taking action to prevent or manage clinical, administrative, property and occupational health and safety risks in the facility in accordance with relevant legislation.
Risk register	A document containing all identified risks for the facility. Each risk should be rated according to a risk matrix. Each risk should be described in terms of source and nature of the risk. The risk register should also record the available mitigation strategies, existing counter-measures in place, recommended additional counter-measures and the frequency with which the risk should be monitored.

Risk matrix	A risk management tool that allows the ranking of risks according to the severity of the impact of the risk and the probability of the risk occurring.
Safety	The degree to which potential risks and unintended results associated with health care are avoided or minimised.
Seamless continuum of care	In the ideal healthcare system, care is delivered in an integrated, uninterrupted, or 'seamless' flow. It is defined as an integrated, patient-oriented system of care composed of both services and integrating mechanisms that guides and tracks patients over time through a comprehensive array of health, mental health and social services spanning all levels of intensity of care.
Setting	The particular healthcare environment that is appropriate for the patient's needs during the continuum of care, i.e. inpatient care, outpatient attendance, rehabilitative and restorative unit, or community setting.
Staffing establishment	This will include available or approved posts, filled posts and vacant posts.
Staffing plan	This defines the human resource requirements to deliver the desired services.
System	A network of interdependent components that work together to attain the goals of the complex whole (WHO).
Personnel	All individuals employed by the facility – this includes full-time, parttime, casual or contract, clinical and non-clinical personnel.
Personnel development	The formal and informal learning activities that contribute to personal and professional growth, encompassing induction, inservice training and continuing education.
Stakeholder	Individual, organisation or group that has an interest or share in services.
Standards	1. The desired and achievable level of performance corresponding with a criterion or criteria against which actual performance is measured. 2. For the purposes of accreditation, a predetermined expectation set by a competent authority that describes the acceptable level of performance of a healthcare facility or individual in relation to structures in place, conduct of a process, or measurable outcome achieved.
Standard development	Standards for evaluation may be developed in three stages: 1. *Normative development* entails establishing what experts believe should happen. 2. *Empirical standards* reflect what is achievable in practice. 3. A *compromise* between what is professionally optimal and what can reasonably be expected to operate.
Standard, minimum	A predetermined expectation set by a competent authority that describes the minimally acceptable level of: a. structures in place b. performance of a process and/or c. measurable outcome that is practically attainable.

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

Team	A number of people with complementary skills whose functions are interdependent. They work together for a common purpose or result (outcome) on a short-term or permanent basis. Examples include project, problem-solving, quality improvement and selfmanaged teams. (See also *multidisciplinary team* and *professional team*.)
Thermolabile	All products which require constant cold storage at productspecific temperatures below room temperature. This also includes vaccines which are normally stored between 2°C and not exceeding 8°C. "Cold chain products" bears the corresponding meaning (SA Good Pharmacy Practice).
Timeliness	The degree to which care is provided to the patient at the most beneficial or necessary time.
Trend	The general direction in which something is developing or changing, for example, an upward trend in wound infections.
User	Someone who uses or could use the services offered by the facility.
Utilisation management	Proactive process by which a facility works towards maintaining and improving the quality of service through the effective and efficient use of human and material resources.
Utilisation review	A method of controlling utilisation that may be: *Prospective* (preadmission certification) – The purpose is to assess whether hospitalisation has been justified and is diagnosisindependent. *Concurrent* – Conducted to assess inpatient care at the time it is provided – the use of resources, the timeliness with which treatment is provided, and the adequacy and timeliness of discharge planning. *Retrospective* – Follows a patient's discharge from the facility or any patient who has received ambulatory care.
Validation of survey	A process whereby a COHSASA facilitator assesses the completed self-assessment documents of a facility. The validation ensures that criteria have been correctly interpreted, appropriately answered and that the technical aspects of the assessment have been correctly addressed. The facilitator uses the opportunity to provide education and consultation on standard interpretation and compliance.
Vision	A short, succinct statement of what the facility intends to become and to achieve at some point in the future.
Vulnerable adult	"A person aged 18 or over who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation" ("No Secrets" DoH 2000).
Waste management	Collection, treatment, storage, transportation and disposal of waste material, including biomedical, household, clinical, confidential and other waste.
Workload measurement	Manual or computerized tool for assessing and monitoring the volume of activity provided by a specific team in relation to the needs for the care and treatment or service they are providing.

PRIMARY HEALTHCARE FACILITIES QUALITY STANDARDS

SERVICE ELEMENTS, RELEVANT STANDARDS AND CRITERIA

1. MANAGEMENT AND LEADERSHIP

OVERVIEW OF MANAGEMENT AND LEADERSHIP:

Effective management of a healthcare facility begins with understanding the various responsibilities and authorities of individuals in the healthcare facility and how these individuals work together.

At governance level, there is an entity, i.e. a national health department, district authority or regional authority, responsible for directing the operation of the community healthcare facility service and accountable for providing a quality service to the population that seeks care. The responsibilities of the governing authority lie primarily in providing systems, guidelines and resources to enable the healthcare facility personnel to reach their objectives. It is the responsibility of the national body to define what services are required to best meet the health needs of the community.

The regional government define how these services are to be implemented by the community healthcare facility services. Direction for the provision of services is provided from district or regional level. Managers at this level ensure that centralised expertise is provided to support personnel of community healthcare facility services in all their activities. This is provided through visits, written communication, monitoring and education.

At the service level, a manager is appointed for day-to-day management. He or she ensures that the policies of the governing authority are implemented and that policies and procedures, appropriate to the specific service, are developed and implemented. The responsibilities of this manager are documented and are known to personnel of the service.

While managers are appointed to posts in the health service, the community healthcare facility also identifies persons who take leadership roles such as senior nurses. These leaders take responsibility for forming teams, which ensure quality in all aspects of patient care. This can usually be done without additional resources but it does lead to the improved use of existing resources.

The lines of responsibility and accountability are documented and are made easy to follow by being depicted in an organogram. The structure of the healthcare facility depicts all established posts and explains the lines of accountability for each post incumbent. Personnel in the service need to know how these lines of accountability work both within the service and up to the national level.

The leaders are recognised and brought into the process of defining the health service's mission. Based on that mission, they work collaboratively to develop the plans and policies needed to fulfil the mission and to coordinate and integrate the health service's activities.

The lines of communication for achieving these goals are represented on a healthcare facility chart. The healthcare facility structure includes all members of the health service, including those persons at the governing level, to whom the managers have lines of responsibility and accountability. Documents prepared by each healthcare service define their goals and identify current and planned services. The managers of each healthcare service/department make their human resources and other resource requirements known to the governing authority. This helps to ensure that adequate human resources, space, equipment and other resources are available to meet patients' needs at all times. The service/department manager is accountable for the cost-effective use of resources.

STANDARDS:

1.1 Governance of the healthcare facility

1.1.1 The governing body's accountability and responsibilities are documented and are known to the healthcare facility managers.

STANDARD INTENT:

Governance is defined as the act of governing. It relates to decisions that define expectations, grant power or verify performance. It consists of either a separate process or part of management or leadership processes.

There is a governing body responsible for directing the operation of the healthcare facility which is accountable for providing quality healthcare services to its community or to the population that seeks care. The responsibilities and accountability of this entity are described in a document that identifies how they are to be carried out and are known to those responsible for management within the healthcare facility. The responsibility of the governing body lies primarily in approving plans and documents submitted by the managers of the healthcare facility. Those elements of management requiring approval by governance are documented.

The process and practices that will apply will vary significantly given the environment in which they are applied. Governance in the public sector, which includes Ministries, Boards and similar entities, considers legal and constitutional accountability and responsibilities.
In the case of a business or a non-profit organisation, governance relates to consistent management, policies, processes, guidance and decision-rights for a given area of responsibility.

It is important that the healthcare facility has clear leadership, operates efficiently, and provides quality healthcare services. The lines of communication for achieving these goals are presented in an organisational chart or another document.

CRITERIA:

1.1.1.1 Documents describe governance accountability and responsibilities.

1.1.1.2 There is an organisational chart or document which describes the lines of authority and accountability from governance and within the service.

1.1.1.3 The responsibilities of governance include providing support to personnel in the healthcare facility.

1.1.1.4 The support from regional or district managers includes regular supervisory visits, monitoring, written communication and education.

1.1.1.5 The facility has a valid licence, issued by an acknowledged healthcare licensing authority, to operate as a healthcare facility.

1.1.1.6 This licence covers all services offered by the facility.

1.1.1.7 The pharmacy is licensed by the country's pharmacy council or equivalent body.

1.1.1.8 The laboratory is licensed by the country's laboratory council or equivalent body.

1.1.1.9 The diagnostic imaging service is licensed by the country's radiation control council or equivalent body.

1.2 Management of the healthcare facility

1.2.1 A senior manager is responsible for operating the healthcare facility ethically and within applicable laws and regulations.

STANDARD INTENT:

The facility manager is appointed by the organisation to be responsible for the overall, day-to-day operation of the healthcare facility. These responsibilities are documented and known to personnel of the healthcare facility. The individual appointed to carry out these functions has the education and experience to do so.
The facility manager is responsible for the implementation of all policies, which have been approved by the governing body.

CRITERIA:

1.2.1.1 The facility manager position has been filled for the past year.

1.2.1.2 The facility manager manages the day-to-day operation of the service.

1.2.1.3 The facility manager has the education and experience to carry out his or her responsibilities.

1.2.1.4 The facility manager ensures that approved policies are implemented.

1.2.1.5 The facility manager ensures compliance with applicable laws and regulations.

1.2.1.6 The facility manager implements processes to manage and control human, financial and other resources.

1.2.1.7 The facility manager ensures that services described in the strategic plan are provided.

1.2.1.8 The facility manager establishes processes to receive and resolve ethical dilemmas within a specified time frame according to policy.

1.2.1.9 Contracts and other arrangements are monitored to ensure that the terms of the contracts are met.

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

STANDARD INTENT:

A standard method of accounting and reporting is essential for efficient delivery of quality health care. Efficient, cost-effective and sustainable service delivery depends upon having up-to-date and accurate financial accounts. A budgeting process results in a defined method of allocating resources. Financial planning and management needs to be conducted by a person who is suitably qualified and experienced in all matters relating to the healthcare facility's finances. This person must be able to identify financial constraints and possibilities and be able to respond by developing accurate policies or procedures. This person must also be able to advise on, what, when and how much to invest as a result of a thorough analysis of plans. Clinical and other leaders need to be included in planning their financial requirements. They also require information relating to the funds available to them for managing their departments and up-to-date statements of current expenditure. Sound accounting and auditing practices are implemented to ensure transparency.

CRITERIA:

1.2.2.1 There are written policies and procedures for accounting functions.

1.2.2.2 The accounting function is performed by an individual with appropriate training and experience.

1.2.2.3 The qualified accounting personnel ensure that policies and procedures are available to guide all personnel and that they are implemented.

1.2.2.4 There are written policies and procedures for maintaining internal and external financial audit systems that meet audit requirements.

1.2.2.5 There are written policies and procedures for the payment of creditors.

1.2.2.6 There is a budgeting process.

1.2.2.7 The budgeting process is prepared in a timely manner and is used for expenditure tracking.

1.2.2.8 There is an asset register, which is routinely maintained.

1.2.2.9 There is an inventory, which is checked according to policy.

1.2.2.10 There is a mechanism for ensuring that the level of debtors is kept to the minimum.

1.2.2.11 There is an effective system for invoicing and billing patients for healthcare services rendered, which includes data quality checks.

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

STANDARD INTENT:

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

Leaders may have formal titles or be informally recognised for their seniority, stature, or contribution to the healthcare facility. It is important that all the leaders of a healthcare facility are recognised and brought into the process of defining the healthcare facility's mission. The leaders work collaboratively to develop the plans and policies needed to fulfil the mission.

CRITERIA:

1.2.3.1 A senior management team is responsible for operating the facility.

1.2.3.2 The facility's clinical leaders are identified and are collectively responsible for creating plans to fulfil the organisation's mission.

1.2.3.3 The leaders are collectively responsible for ensuring that the mission statement is known to all personnel, patients, carers and the community served.

1.2.4 The healthcare facility manager plans for the type of services required to meet the needs of the patients served by the facility in consultation with community members and/or stakeholders.

STANDARD INTENT:

patient care services are planned and designed to respond to the needs of the patient population. the care and services (as well as scope and intensity) to be provided are documented and are consistent with the healthcare facility's mission and comply with national rules and regulations. planning patient care services also involves healthcare facility leaders defining its communities and patient populations, identifying community needs for services and planning ongoing communication with those key community stakeholder groups. the communication may be directly to individuals or through public media and through agencies within the community or third parties. the healthcare facility leader(s) are aware of and utilize the capacity of relevant healthcare providers in the area for effective referral of patients and continuity of care.

CRITERIA:

1.2.4.1 The healthcare facility's manager promotes networking with the leaders of other relevant organisations in the community.

1.2.4.2 There is evidence of meetings with representatives of the community.

1.2.4.3 Community leaders (including traditional healers where appropriate) are represented.

1.2.4.4 The facility is aware of and accesses services from other provider facilities operating in the area.

1.2.5 The healthcare facility's leaders ensure that policies and procedures are implemented to support the activities of the healthcare facility and to guide personnel, patients and visitors.

STANDARD INTENT:

Policies and procedures are formulated at different levels of authority, for example, national acts and regulations, national health and labour departmental policies, regional policies and healthcare facility policies.

Leaders must ensure that all policies applying to the healthcare facility are available to personnel and that they are implemented and monitored as they relate to various departments, services and functions. Leaders should ensure that policies and procedures are available to guide personnel in such matters as allocation, use and care of resources, financial practices, human resource management and dealing with complaints from patients and visitors.

The availability and application of specific policies and guidelines will be assessed and measured in the relevant services.

CRITERIA:

1.2.5.1 The healthcare facility's manager ensures that policies and procedures guide and support the activities and management of the healthcare facility.

1.2.5.2 A designated personnel member is responsible for compiling and indexing policies and procedures, and ensuring their circulation, recall and review.

1.2.5.3 Policies and procedures are signed/endorsed by persons authorised to do so.

1.2.5.4 Policies and procedures are compiled and indexed in a manner that is easily accessible to all personnel.

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

1.2.5.6 There is a mechanism for ensuring that policies are known and implemented.

1.2.6 The organisation ensures that supplies and provisions are ordered, received, safely stored and provided to departments in time to meet their needs.

STANDARD INTENT:

Supply chain management is an important process to ensure that necessary supplies are available on time and to prevent medication, medical technology, and supplies that are contaminated, fake or from diverted sources reaching the healthcare facility's patients. Although there is no single global standard for supply chains, or even national standards in many countries, it is the responsibility of healthcare facility leadership to ensure that a system is implemented to protect the integrity of supplies and equipment.

The available storage facilities should be adequate for the needs of the healthcare facility. The storage needs of the healthcare facility are dependent on the type of the product (to be refrigerated or dangerous), on the size of the healthcare facility, the number of services and the number of patients.

CRITERIA:

1.2.6.1 A suitably qualified individual is designated to control the ordering, storage, distribution and control of equipment and supplies used in the organisation.

1.2.6.2 There is a system for ensuring that equipment and supplies are ordered, available, correctly stored and distributed.

1.2.6.3 A list of approved suppliers is available.

1.2.6.4 There is a system for monitoring the quality of goods delivered.

1.2.6.5 There is a system for monitoring the use of resources and taking corrective actions when required.

1.2.6.6 Secure, adequate storage facilities are available.

1.2.6.7 Records are kept of goods received and goods issued.

1.2.6.8 The "first expired first out" principle is applied to avoid outdated stock.

1.2.6.9 There is a system for disposing of expired stock, including pharmaceuticals.

1.3 Quality leadership and design

1.3.1 A quality improvement system is in place.

STANDARD INTENT:

If a healthcare facility is to initiate and maintain improvement, leadership and planning are essential.

A comprehensive approach to quality management and improvement includes the following processes:

- Planning for improvement in quality
- Monitoring how well processes work through indicator data collection
- Analysing the data
- Implementing and sustaining changes that result in improvement

These processes, when performed well, provide the framework for the healthcare facility and its leaders to achieve the objective of providing quality patient care in a safe, well-managed environment. The continuous monitoring, analysing and improving of clinical and managerial processes must be well organised and have clear leadership to achieve maximum benefit.

The framework presented in the standards is suitable for a wide variety of structured programmes and less formal approaches to quality management and improvement. This framework can also incorporate traditional monitoring programmes such as those related to unexpected events (risk management) and resource use (utilisation management).

Well-designed processes or services draw on a variety of information sources. Good process design:

- Is consistent with the healthcare facility's mission and plans
- Meets the needs of patients, families, personnel and others
- Uses current practice guidelines, clinical standards, scientific literature and other relevant evidence-based information on clinical practice design
- Is consistent with sound business practices
- Considers relevant risk management information
- Uses information from related improvement activities
- Integrates and connects processes and systems

A primary responsibility of leaders is to set priorities. Health facilities typically find more opportunities for quality monitoring and improvement than they have human and other resources to undertake such processes. The leaders therefore provide focus for the facility’s quality monitoring and improvement activities. The leaders prioritise those critical, high-risk or problem-prone processes that most directly relate to the quality of care and the safety of the environment. The leaders use available data and information to identify areas that must be prioritised.

CRITERIA:

1.3.1.1 There is a relevant training programme to equip personnel with the necessary competencies for designing, implementing and evaluating a quality management and improvement programme.

1.3.1.2 The healthcare facility’s manager and personnel collaborate to plan and carry out the quality improvement and patient safety programme.

1.3.1.3 The healthcare facility’s manager and personnel monitor the quality of data collected by the institution.

1.3.1.4 The healthcare facility’s manager and personnel design new and modified systems and processes according to quality improvement principles.

1.3.1.5 The quality management and improvement programme reflects the scope of service delivery in relation to managerial, clinical and support services.

1.3.1.6 The quality management and improvement programme reflects all components and quality activities in relation to standard/indicator development, monitoring/evaluation and remedial action.

1.3.1.7 There is a process for reviewing patient care.

1.3.1.8 There is a process for reviewing medication use.

1.3.1.9 There is a process for monitoring patient satisfaction with the care process, the care environment and the facility's personnel.

1.3.1.10 There is a relevant/appropriate system for reporting on quality management and improvement matters and communicating with all stakeholders concerned.

1.3.2 Improvement in quality is achieved and sustained.

STANDARD INTENT:

The healthcare facility uses the information from data analysis to identify potential improvements to reduce or prevent adverse events. Routine monitoring data and data from intensive assessments contribute to an understanding of where improvement should be planned, and what priority should be given to the improvement. In particular, clinical and managerial leaders plan improvements to those data collection areas requiring priority.

The healthcare facility uses appropriate resources and involves those individuals, disciplines, and departments closest to the processes or activities to be improved. Responsibility for planning and carrying out improvement is assigned to individuals or to a team. Any necessary training is provided and information management or other resources are made available.

Once a change is planned, data is collected during a test period to demonstrate that the change is an improvement. To ensure that the improvement is sustained, monitoring data is then collected for ongoing analysis. Effective changes are incorporated into standard operating procedures and any necessary education of personnel is carried out. The healthcare facility documents improvements achieved and sustained as part of its quality management and improvement processes.

CRITERIA:

1.3.2.1 The organisation documents the improvements achieved and sustained over time.

1.3.2.2 The data collected for monitoring and evaluation purposes is used to inform the development of processes to ensure that improvements are sustained over time.

2. HUMAN RESOURCE MANAGEMENT

OVERVIEW OF HUMAN RESOURCE MANAGEMENT:

A healthcare facility needs an appropriate number of suitably qualified people to fulfil its mission and meet patient needs.

Recruiting, evaluating and appointing personnel are best accomplished through a coordinated, efficient and uniform process. It is usual for this to be done at a central point. It is also essential to document an applicant's skills, knowledge, education and previous work experience. It is particularly important to review the credentials of medical and nursing personnel carefully because they are involved in clinical care processes and work directly with patients.

Individual personnel members have their responsibilities defined in a current position description. The position description is the basis for assignment, orientation to their work and evaluation of how well they fulfil their position responsibilities. Consultant personnel have their responsibilities defined in contract agreements.

Healthcare facilities should provide their personnel with opportunities to learn and advance personally and professionally. In-service education and other learning opportunities should therefore be offered to them.

STANDARDS:

2.1 Personnel planning

2.1.1 There is a plan for the provision of adequate numbers of suitably qualified and identified personnel.

STANDARD INTENT:

Appropriate and adequate personnel are critical to patient care. The healthcare facility's leaders define the desired education, skills, knowledge and any other requirements as part of projecting personnel complements and needs.

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

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

- Personnel recruitment
- The numbers and categories of personnel required
- The desired education, qualifications, skills and knowledge
- Assignment and reassignment of personnel
- Personal development of personnel
- Personnel retention

CRITERIA:

2.1.1.1 There are documented processes for staffing the healthcare facility.

2.1.1.2 The desired education, qualifications, skills and knowledge are defined for all personnel.

2.1.1.3 The scope of practice of those permitted to provide patient care without supervision is identified.

2.1.1.4 There are implemented processes to ensure that individuals responsible for patient care are identified and made known to the patient and other personnel.

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

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

2.2 Personnel management

2.2.1 Personnel files are maintained for all employees.

STANDARD INTENT:

Each personnel member in the healthcare facility has a record with information about his/her qualifications, results of evaluations and work history. These records are standardised and are kept current.

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

Personnel files must contain as a minimum:

a) Verified copies of diplomas and/or licences
b) The current position description signed by the personnel member
c) Evidence of orientation to the facility
d) Copies of records of in-service education received
e) Copies of at least annual performance appraisals

CRITERIA:

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

2.2.1.2 There is documented personal information on each personnel member.

2.2.1.3 Personnel files are kept current and reviewed annually.

2.2.1.4 Personnel files contain the documents listed in a) – e) in the standard intent above.

2.2.1.5 Only authorised persons have access to personnel records.

2.2.2 Each personnel member's responsibilities are defined in a current position description/performance agreement.

STANDARD INTENT:

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

CRITERIA:

2.2.2.1 Each personnel member has a written position description/performance agreement, which defines their responsibilities.

2.2.2.2 Each personnel member signs their position description/performance agreement to show that that they accept it.

2.2.2.3 Position descriptions/performance agreements are reviewed according to organisational policy.

2.2.3 The healthcare facility uses a defined process to evaluate the knowledge and skills of personnel to ensure that these are consistent with patient needs.

STANDARD INTENT:

The healthcare facility defines the process for and the frequency of ongoing evaluation of the abilities of personnel. Ongoing evaluation ensures that training occurs when needed and that personnel are able to assume new or changed responsibilities. While such evaluation is best carried out in an ongoing manner, there is a least one documented evaluation each year for each personnel member.

CRITERIA:

2.2.3.1 The personnel member's registration, education, recognised scope of practice, training and experience are used to authorise the individual to provide clinical services consistent with his/her qualifications.

2.2.3.2 There is at least one documented appraisal of each personnel member each year or more frequently as defined by the healthcare facility.

2.2.3.3 New personnel are evaluated as determined by organisational policy.

2.3 Credentialing

2.3.1 There is an effective process for gathering, verifying and evaluating the credentials (registration, education, training and experience) of those healthcare professionals who are permitted to provide patient care without supervision.

STANDARD INTENT:

Healthcare professionals who are registered to provide patient care without clinical supervision are primarily responsible for patient care and care outcomes. These professionals usually include doctors, dentists, professional nurses, radiographers and members of other professions allied to medicine. The healthcare facility needs to ensure that it has qualified health professionals who appropriately match its mission, resources and patient needs.

An individual's credentials consist of an appropriate current registration, completion of professional education and any additional training and experience. There is a process for gathering this information, verifying its accuracy where possible and evaluating it in relation to the needs of the healthcare facility

and its patients. This process can be carried out by the healthcare facility or by an external agency such as a ministry of health in the case of public health facilities.

The process applies to all types and levels of employees (employed, honorary, contract and private practitioners). Evaluating an individual's credentials is the basis for two decisions: whether this individual can contribute to fulfilling the organisation's mission and meeting patient needs, and, if so, what clinical services this individual is qualified to perform.
These two decisions are documented, and the latter decision is the basis for evaluating the individual's ongoing performance.

CRITERIA:

2.3.1.1 There is a process for evaluating and verifying the credentials (licence, education, training and experience) of physicians, nurses and other healthcare professionals.

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

2.3.1.3 There is a system in place that tracks the annual registration of professionals with the relevant professional Councils, with documented actions taken as required.

2.4 Personnel orientation and education

2.4.1 All personnel are oriented and inducted to the healthcare facility and to their specific position responsibilities at the time of appointment.

STANDARD INTENT:

The decision to appoint an individual to the personnel of a healthcare facility sets several processes in motion. To perform well, a new personnel member needs to understand the workings of the entire healthcare facility and how his/her specific responsibilities contribute to the healthcare facility's mission. This is accomplished through a general orientation to the healthcare facility and his/her role in the facility and a specific orientation to the responsibilities of his/her position. The healthcare facility includes, as appropriate, the reporting of medical errors, infection control practices, the healthcare facility's policies on telephonic medication orders, and so on.

It is important to orientate and induct all doctors. Contract workers and volunteers are also oriented to the healthcare facility and their specific assignment or responsibilities, such as, for example, patient safety and infection control.

CRITERIA:

2.4.1.1 There are written programmes for orienting and inducting personnel to the healthcare facility, their position responsibilities and their specific assignments.

2.4.1.2 There are written programmes for orienting and inducting contract workers and volunteers to the healthcare facility, their position responsibilities and their specific assignments.

2.4.1.3 New personnel members, contract worker and volunteers are orientated to the healthcare facility within a time frame determined by healthcare facility policy.

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

STANDARD INTENT:

The healthcare facility has a responsibility to ensure that personnel are educated in matters that affect their functioning in the specific healthcare facility. In particular, personnel are trained in health and safety matters, infection control and cardiac life support.

The healthcare facility also collects and integrates data from several sources to understand the ongoing educational needs of personnel. Such sources include monitoring data from the facility management programme, the introduction of new technology, skills and knowledge areas identified through the review of job performance, new clinical procedures and future plans and strategies of the healthcare facility.

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

CRITERIA:

2.4.2.1 The healthcare facility has a written plan for in-service education.

2.4.2.2 The healthcare facility uses various sources of data and information to identify the in-service training/education needs of personnel.

2.4.2.3 All healthcare facility personnel are provided with on-going in-service education/training.

2.4.2.4 Personnel competencies, where relevant, are assessed and recorded after inservice training/education.

2.4.3 Personnel participate in continuing education, research and other educational experiences to acquire new skills and knowledge and to support position advancement.

STANDARD INTENT:

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

CRITERIA:

2.4.3.1 The healthcare facility supports continuing education for its professional personnel and maintains records of this in personnel files.

2.4.3.2 There is a development strategy for the healthcare facility that ensures that managers receive the training required to fulfil their responsibilities.

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

3. PATIENT RIGHTS AND ACCESS TO CARE

OVERVIEW OF PATIENT RIGHTS AND ACCESS TO CARE:

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

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

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

How these processes are carried out in a healthcare facility depends on Namibia's laws, regulations and charters and any international conventions, treaties or agreements on human rights endorsed by Namibia.

In order to meet the community's need for services, the healthcare facility must clearly define the boundaries of the community and the boundaries of the services provided by the healthcare facility. Service managers are competent in defining these geographic areas and assessing the social and healthcare needs of their inhabitants. Equitability and availability of service provision are assisted through community participation.

Patients and their families need complete information on the care and services offered by the healthcare facility as well as how to access those services. Providing this information is essential to building open and trusting communication between patients, their families and the healthcare facility. Such information helps match the patient's expectations with the ability of the healthcare facility to meet those expectations.

When the necessary care is beyond the healthcare facility's mission and capabilities, information on alternative sources of care and services is provided.

The service provides coordination with other services in the district and ensures that patients are appropriately referred to the services that meet their ongoing care needs. All patients are referred to the next level of care when their needs fall beyond the scope and competence of the healthcare facility’s personnel. Patients who need additional health or social services are referred appropriately. Guidelines are available for patient referral.

STANDARDS:

3.1 Implementation of patient rights

3.1.1 The healthcare facility has a patient rights policy.

STANDARD INTENT:

A healthcare facility's leaders are primarily responsible for the way in which that healthcare facility treats its patients. The leaders need to know and understand patient and family rights and their healthcare facility's responsibilities as specified in Namibian laws, charters and regulations. The leaders then provide direction to ensure that personnel throughout the healthcare facility assume responsibility for protecting these rights. To effectively protect and advance patient rights, the leaders work

collaboratively and seek to understand their responsibilities in relation to the community served by the healthcare facility.

Patient and family rights are a fundamental element of all contacts between personnel of a healthcare facility and patients and families. Policies and procedures are developed and implemented to ensure that all personnel are aware of and respond to patient and family rights issues including their role in supporting the right of patients and families to participate in the care process. The following policies need to be implemented at as a minimum: a) The right to privacy
b) The right to dignity and respect
c) The right to confidentiality of information
d) The right to personal safety and security
e) The right to consent to and refuse treatment

Admission to a healthcare facility can be a frightening and confusing experience for patients, making it difficult for them to understand and act on their rights. The healthcare facility must therefore prepare a written statement of patient and family rights and ensure that patients receive a copy when they enter the healthcare facility for care and that it is available throughout their stay. For example, the statement may be displayed as a poster in the facility.

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

CRITERIA:

3.1.1.1 There is an organisational policy regarding patient and family rights that includes at least a) – e) in the standard intent above and is implemented.

3.1.1.2 Where applicable, relevant charters, laws and regulations are included in organisational policies regarding patient and family rights.

3.1.1.3 Personnel are trained on the policies and procedures and their participation in care processes.

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

3.2 Protection of privacy

3.2.1 The healthcare facility takes measures to protect patient privacy.

STANDARD INTENT:

The healthcare facility ensures that the patient's need for privacy is respected, especially when the patient is providing personal information and undergoing clinical examination. Patients may desire privacy from other personnel, other patients and even from family members.

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

information can be misused by personnel of the healthcare facility, family members or others not authorised to have access to the information.

CRITERIA:

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

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

3.2.1.3 The patient's right to privacy is protected for all forms of counselling.

3.2.1.4 Policies and procedures to prevent the loss or misuse of patient information are implemented.

3.2.1.5 The policy includes the right to confidentiality of patient records.

3.3 Right to health education

3.3.1 The healthcare facility supports and protects the right of patients and families to participate in the patient care process.

STANDARD INTENT:

Every patient is offered the information and education he or she requires. Health facilities may choose to appoint education coordinators, education committees or they may work with all personnel to provide education in a coordinated manner.

CRITERIA:

3.3.1.1 The healthcare facility plans education consistent with its health facilities and patient population.

3.3.1.2 There is an appropriate structure or mechanism for education throughout the healthcare facility.

3.3.1.3 Patient and family education promotes the concept of taking responsibility for one's own health care.

3.3.1.4 The patient and his/her family are taught in a language and format that they can understand.

3.3.1.5 The healthcare facility identifies and establishes relationships with community resources, which support continuing health promotion and disease prevention education.

3.3.1.6 There is a uniform process for recording patient education information.

3.4 Right to treatment and to refuse treatment

3.4.1 The healthcare facility respects the rights of patients and families to receive treatment and to refuse or discontinue treatment.

STANDARD INTENT:

Patients, or those making decisions on their behalf, may decide not to proceed with the planned care or treatment or to discontinue care or treatment after it has been initiated. The healthcare facility informs patients and families about their right to make these decisions, about the potential outcomes that could result from these decisions and about their responsibilities related to such decisions. Patients and families are given information on any care and treatment alternatives. Personnel are informed of their responsibility to implement and respect the choices of patients.

CRITERIA:

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

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

3.4.1.3 Patients are informed about the consequences of such decisions.

3.5 Right to voice complaints

3.5.1 The healthcare facility informs patients and their families about the processes it has instituted to receive and act on complaints, conflicts and differences of opinion about patient care and the patient's right to participate in those processes.

STANDARD INTENT:

Patients have a right to voice complaints about their care and to have those complaints reviewed and, where possible, resolved. Decisions regarding care sometimes present questions, conflicts or other dilemmas for the healthcare facility and the patient, family or other decision-makers. These dilemmas may arise around issues of access, treatment or discharge. The healthcare facility has established processes for seeking resolutions to such dilemmas and complaints. The healthcare facility identifies in policies and procedures those who need to be involved in the processes and how the patient and family participate.

CRITERIA:

3.5.1.1 There is a mechanism to allow complaints to be heard and acted upon.

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

3.5.1.3 Complaints are recorded, evaluated and analysed.

3.6 Informed consent

3.6.1 The healthcare facility has a clearly defined process for obtaining consent.

STANDARD INTENT:

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

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

CRITERIA:

3.6.1.1 Policies and procedures guide personnel in the process of gaining informed consent.

3.6.1.2 The healthcare facility has a procedure, which is implemented, when others must grant informed consent.

3.7 Access to care

3.7.1 Patients have access to the healthcare facility based on their identified healthcare needs and the healthcare facility's mission and resources.

STANDARD INTENT:

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

CRITERIA:

3.7.1.1 The healthcare facility renders services based on the needs of the population, but at least for eight hours a day, five days a week.

3.7.1.2 The healthcare facility has access to Ambulance Services (EMS).

3.7.1.3 There are appointment systems, where appropriate.

3.7.1.4 Patients who are waiting are advised of any delays that may be experienced in receiving attention.

3.7.2 Measures are in place to ensure that patient access to the healthcare facility is facilitated by adequate infrastructural arrangements.

CRITERIA:

3.7.2.1 There is an access road to the facility.

3.7.2.2 The condition of the road does not restrict patients in reaching the facility.

3.7.2.3 The road is accessible throughout the year (e.g. take a situation like the rainy season into account).

3.7.2.4 Direction signs to the facility are clearly readable and up to date.

3.7.2.5 A telephone/emergency number is available.

3.7.2.6 The name of the organisation and its purpose is clearly indicated on the site.

3.7.2.7 Parking is made available close to the building entrance for patients, including the physically challenged.

3.7.2.8 There is wheelchair access to and within the building.

3.7.2.9 Ramps and stairs include safety features such as rails.

3.7.2.10 Directions to the different departments are clearly indicated.

3.8 Information for patients about the services offered

3.8.1 The healthcare facility has a process for informing patients and their families about its services and how to access those services.

STANDARD INTENT:

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

During the entry process, patients and their families receive sufficient information to make informed decisions about seeking care. Information is provided on proposed care, the expected results and any expected cost to the patient or family for that care, when this is not paid for by a public or private source.

Patients and families need complete information on the care and services offered by the healthcare facility and on how to access those services. Providing this information is essential to building open and trusting communication between patients, families and the healthcare facility. This information helps to match the patient's expectations to the ability of the healthcare facility to meet those expectations. When the necessary care is beyond the healthcare facility's mission and capabilities, information on alternative sources of care and services are provided.

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

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

CRITERIA:

3.8.1.1 Patients are given information about the care and services provided by the healthcare facility.

3.8.1.2 Information is provided in a manner and language that is understood by those making the care decisions.

3.8.1.3 Information on services, hours of operation, and processes for obtaining care is provided to agencies and referral sources in the community, and to the population served.

4. MANAGEMENT OF INFORMATION

OVERVIEW OF MANAGEMENT OF INFORMATION:

Although computerisation and other technologies improve efficiency, the principles of good information management apply to all methods, whether paper-based or electronic. These standards are designed to be equally compatible with non-computerised systems and future technologies.

Each service determines its information requirements for improving managerial and clinical care. Objectives are set for each programme and information is required to ensure that these objectives are met.

Required levels of security and confidentiality are applied. An effective process defines who has access to information, the information to which an individual has access, the user's obligation to keep information confidential and the process followed when confidentiality and/or security are violated. The service develops a policy to authorise such individuals and identifies the content and format for entries into patient records. There is a process for ensuring that only authorised individuals make entries in patient records.

The service's information management plan, once complete and approved, is implemented. The healthcare facility provides personnel, technology and other resources necessary to implement the plan and meet the identified information needs of the healthcare providers, managers and others. The management ensures that personnel have the necessary supplies, registers, check lists, forms, etc. for data management.

Those individuals in the healthcare facility who generate, collect, analyse and use data and information are educated and trained to participate effectively in the management of information and to understand the need for security and confidentiality of data and information.

Aggregated data provides a profile of the service over time and allows the comparison of its performance improvement activities. In particular, aggregated data from patient visits and treatment provided (for example. immunisations) can help the healthcare facility understand its current performance and identify opportunities for improvement. Data is used for utilisation review and for analysing costs per patient.

By participating in external performance databases, a healthcare facility can compare its performance to that of other similar health facilities, locally or nationally. Performance comparison is an effective tool for identifying opportunities for improvement and documenting the service's performance level.

The information management process makes it possible to combine information from various sources and generate reports to support decision-making. In particular, the combination of clinical and managerial information supports the leaders of the healthcare facility to plan collaboratively. The information management process supports leaders with longitudinal and comparative data. Service managers and leaders use this data to improve the quality of the services offered.

The clinical record of each patient needs to contain sufficient information to support the diagnosis, justify the treatment provided and document the care given. Where carry cards are used, there are summaries of each attendance in the service, which will provide this information. A standardised format and content of a patient's record will help promote the integration and continuity of care among the various providers of care to the patient and the healthcare facility determines the specific data and information recorded in the clinical record.

Uniform use of diagnostic and procedure codes supports data aggregation and analysis. Abbreviations and symbols are also standardised. Such standardisation is consistent with recognised local and national standards.

Each service has a process for assessing the quality and completeness of patient records. This is a part of the healthcare facility's performance improvement activities and is carried out regularly. The clinical record review is based on a representative sample of the practitioners providing care and of the types of care provided. The review process is conducted by doctors, nurses and other relevant clinical professionals who are authorised to make entries in the patient records. The focus of the review is on the quality of the records and the clinical information available during the care process. This applies to records kept on carry cards as well as patient files.

STANDARDS

4.1 Information planning

4.1.1 The healthcare facility meets the information needs of all those who provide clinical care, those who manage the service and those outside the healthcare facility who require data and information from the healthcare facility.

STANDARD INTENT:

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

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

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

There is a system integrating administrative data such as numbers of patient per department, enrolment data, utilisation, bed occupancy rates and human resources data which is supported by Information Technology or paper-based administration systems. The collection of data is based on the systematically investigated need for information within the organisation.

CRITERIA:

4.1.1.1 The healthcare facility uses a health information system that facilitates the collection and utilisation of data.

4.1.1.2 The information system includes data required to measure the objectives set for each programme provided by the healthcare facility.

4.1.1.3 The requirements for the collection, collation, validation and distribution of data are clearly defined in the system.

4.1.1.4 The system identifies who is permitted access to each category of data and information.

4.1.1.5 The healthcare facility collects data in a timely and efficient manner.

4.1.1.6 Systems are in place for the storage and retrieval of patient information.

4.2 Analysis of data

4.2.1 There is a relevant system for the analysis of data.

STANDARD INTENT:

To reach conclusions and make decisions, data must be aggregated, analysed and transformed into useful information. Data analysis involves individuals with an understanding of information management and skills in data aggregation methods and in the use of various statistical tools. Data analysis involves the individuals responsible for the process or outcome being measured. These individuals may be clinical, managerial or a combination of both. Data analysis provides continuous feedback of quality management information to help those individuals make decisions and continuously improve clinical and managerial processes.

The healthcare facility determines how often data is aggregated and analysed. The frequency depends on the activity or area being measured, the frequency of measurement, and the healthcare facility's priorities. For example, clinical data may be analysed weekly to meet local regulations and patient fall data may be analysed monthly if falls are infrequent. Aggregation of data at points in time therefore enables the healthcare facility to judge a particular process's stability or a particular outcome's predictability in relation to expectations. When the healthcare facility detects or suspects an undesirable change from what is expected, it initiates intense analysis to determine where best to focus improvement. In particular, intense analysis is initiated when levels, patterns or trends vary significantly or undesirably from:

- What is expected
- Those of other health facilities
- Recognised standards

Certain events related to specific processes always result in intense analysis to understand the cause and prevent recurrence. When appropriate to the healthcare facility's services, these events include:

- Confirmed transfusion reactions
- Significant adverse drug reactions
- Significant medication errors
- Significant discrepancies between preoperative and postoperative diagnoses • Significant adverse anaesthetic events

Each healthcare facility establishes which events are significant and the process for their intense analysis.

When undesirable events can be prevented, the healthcare facility works to carry out preventive changes.

The goal of data analysis is to be able to compare a healthcare facility in four ways:

- With itself over time, such as month to month or one year to the next
- With other similar health facilities, such as through reference databases
- With standards, such as those set by accrediting and professional bodies or those set by Namibian laws or regulations
- With desirable practices identified in the literature, such as practice guidelines

These comparisons help the healthcare facility to understand the source and nature of undesirable change and help to focus improvement efforts.

Understanding statistical techniques is helpful in data analysis, especially in interpreting variation and in deciding where improvement is needed. Run charts, control charts, histograms and Pareto charts are examples of statistical tools that are useful when seeking to understand trends and variations in health care.

CRITERIA:

4.2.1.1 Data is aggregated, analysed and transformed into useful information.

4.2.1.2 The frequency of data analysis is appropriate to the process under study.

4.2.1.3 The frequency of data analysis meets the requirements of the healthcare facility.

4.2.1.4 Intense analysis of data takes place when there are significant adverse levels, patterns or trends, as established by the healthcare facility.

4.2.1.5 Statistical tools and techniques are used in the analysis process when suitable.

4.3 Information usage

4.3.1 Health statistics are collected as required and reported in a timely manner to responsible officers.

CRITERIA:

4.3.1.1 The healthcare facility contributes to external reference databases when required by laws or regulations.

4.3.1.2 The healthcare facility manager or delegated person checks data leaving the facility for completeness, correctness and consistency.

4.3.1.3 The performance of the facility on identified priority indicators forms part of the discussions at regular personnel meetings.

4.3.1.4 The performance of the facility on identified priority indicators forms part of the discussions at meetings with community representatives.

4.3.1.5 Targets for identified priority indicators are known to the facility manager and the information coordinator for the facility.

4.3.1.6 The facility uses information from external data sources for benchmarking.

4.3.2 There is a programme for using information to improve practice.

CRITERIA:

4.3.2.1 Data relating to the meeting of objectives for each programme are made available to the healthcare facility personnel at least quarterly.

4.3.2.2 Data is analysed and used to provide relevant information for improving the clinical service.

4.3.2.3 There is a regular scheduled meeting, at least quarterly, to review institutional mortalities and morbidities.

4.4 Patient health records

4.4.1 The organisation has defined the type and content of patient records.

CRITERIA:

4.4.1.1 There are written policies and procedures relating to the type of patient record used, e.g. carry cards or other health records.

4.4.1.2 Policies specify the records or registers relating to the visits of each patient to be kept by the healthcare facility.

4.4.1.3 Standardised diagnostic and procedure codes are used, if required.

4.4.1.4 Symbols and definitions are standardised.

4.4.1.5 Each patient has a record which is provided with a unique number.

4.4.2 Patient records contain the required information.

STANDARD INTENT:

There is a clinical record for each patient, which contains sufficient information to identify the patient, including an intake history and a physical examination that supports the diagnosis, justifies the treatment, documents the course and results of treatment and promotes continuity of care among healthcare providers.

CRITERIA:

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

4.4.2.2 The complete patient record containing notes by medical, nursing and other health professionals should be readily available to healthcare providers.

4.4.2.3 There is a standardised format for recording patient assessment and treatment.

4.4.2.4 The signature and designation can be identified for each patient record entry.

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

4.4.2.6 The plan of care for each patient is noted in the patient record.

4.4.2.7 Nursing care plans are updated after each shift.

4.4.2.8 All procedures and diagnostic tests requested are noted in the patient's record.

4.4.2.9 There is evidence of review of the results of procedures and diagnostic tests performed.

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

4.4.2.11 Prescribed and administered medication is recorded for each patient.

4.4.2.12 Adverse drug reactions are noted in the patient's record.

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

4.4.2.14 Patient and family education provided is noted in the patient's record.

4.4.2.15 Follow-up instructions are recorded in the patient's record.

4.4.2.16 Patient records are reviewed regularly and results analysed as part of the quality improvement process.

4.4.3 A discharge summary is written for each inpatient and made available in the patient's record.

STANDARD INTENT:

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

The summary contains at least:

a) The reason for admission
b) The diagnosis of main and significant illnesses
c) The results of investigations that will influence further management
d) All procedures performed
e) The patient's condition at discharge
f) Discharge medication and follow-up instructions

CRITERIA:

4.4.3.1 A discharge summary, which includes items a) to f) in the intent statement, is written by the medical practitioner at the discharge of each patient.

4.4.3.2 Each record contains a copy of the discharge summary.

4.5 Health record maintenance

4.5.1 There is an established health record storage system that ensures confidentiality and safety.

STANDARD INTENT:

Health record management must be implemented by a person with suitable training and experience. The manager controls the safe storage and retrieval of files. Files must be readily available each time the patient visits a healthcare professional and must therefore be filed in such a way that they are easily identified. Policies and procedures as well as managerial supervision ensure the safety and confidentiality of files. Loss of information may be through electronic failure, fire, flood or theft. The

organisation develops and implements a policy that guides the retention of patient records and other data and information. Patient records and other data and information are retained for sufficient periods to comply with Namibian law and regulation and support patient care, the management of the organisation, legal documentation, research and education. The retention policy is consistent with the confidentiality and security of such information. When the retention period is complete, patient records and other data and information are destroyed appropriately.

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

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

CRITERIA:

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

4.5.1.2 The healthcare facility manager ensures that policies and procedures are implemented to guide personnel.

4.5.1.3 Policies and procedures relate to the safeguarding of information in the record against loss, damage, breach of confidentiality or use by unauthorised persons.

4.5.1.4 There is a system which allows for the rapid retrieval and distribution of health records.

4.5.1.5 The filing system allows for incorrectly filed records to be easily identified (e.g. through colour coding of the records).

4.5.1.6 The healthcare facility has a policy on the retention of patient records and other data and information.

4.5.1.7 The retention process provides the necessary confidentiality and security.

4.5.1.8 Policies and procedures are developed for health record destruction, specifying the criteria for selection and the method of destruction.

4.5.1.9 There is provision for authorised access to patient records at all times.

4.5.1.10 Storage space for health records is sufficient and secure against unauthorised entry.

5. RISK MANAGEMENT

OVERVIEW OF RISK MANAGEMENT:

Health facilities work to provide a safe, functional and supportive facility for patients, families, personnel, volunteers and visitors. To reach this goal, facilities, equipment and medication must be effectively managed. In particular, management must strive to:

- Identify, evaluate, reduce and control hazards and risks
- Prevent accidents and injuries
- Maintain a safe environment

Effective management includes planning, education and monitoring of resources needed to safely and effectively support the clinical services provided in the inpatient, day care and home care settings. All personnel are taught how to reduce risks and how to monitor and report situations that pose risk. Criteria are used to monitor important systems and identify needed improvements.

Planning should consider the following areas in all settings, when appropriate to the activities of the organisation.

- Occupational health and safety programmes – the organisation complies with legislation relating to health and safety and risk management
- Fire safety – property and occupants are protected from fire and smoke
- Emergencies – responses to disasters and emergencies are planned and effective
- Hazardous materials – the handling, storage and use of flammable and other materials are controlled and hazardous waste is safely disposed of
- Security – property and occupants are protected from harm and loss

The provision of health and safety services, emergency planning and other aspects of providing a safe environment all require personnel and volunteers to have the necessary knowledge and skills for their implementation.

STANDARDS

5.1 Risk management

5.1.1 Managers and leaders work collaboratively to develop, implement and maintain effective risk management systems in the organisation.

STANDARD INTENT:

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

Risk management includes:

- Comprehensive risk assessment of the organisation and/or facility
- Planning all aspects of the risk management plan (financial, physical, environmental, medico-legal, operational, etc.)
- Implementation of the programme
- Personnel education
- Testing and monitoring the programme
- Periodic review and revision of the programme

Monitoring of all aspects of the programme provides valuable data to make improvements in the programme and further reduce risks within the organisation.

CRITERIA:

5.1.1.1 There are documented risk management processes for identifying all risks (physical, environmental, medico-legal, operational, etc.) relating to organisational processes and systems, personnel, patients, visitors and physical facilities.

5.1.1.2 Management and leaders ensure the development and implementation of written policies and procedures for risk management processes and activities.

5.1.1.3 On-going in-service training of all personnel in these policies, procedures and risk management principles, including reporting of adverse events, is documented.

5.1.1.4 One or more qualified and/or skilled and/or experienced individuals supervise the implementation of the risk management system.

5.1.1.5 There is a system for monitoring negative incidents/near misses/adverse (sentinel) events and it includes the documentation of interventions and responses to recorded incidents.

5.1.1.6 Risk management systems are reviewed whenever there are changes in organisational systems and processes or physical facilities.

5.2 Occupational Health and Safety

5.2.1 Management makes provision for occupational health services in accordance with a documented policy framework.

STANDARD INTENT:

The provision of health and safety services, emergency planning and other aspects of providing a safe environment all require personnel to have the necessary knowledge and skills for their implementation.

To plan effectively, the organisation must be aware of all the risks present in the facility and to develop a proactive plan to reduce those risks, for example, TB screening, manual handling and needlestick injuries.

Simple first aid materials should be available for personnel to treat cuts and other minor injuries.

CRITERIA:

5.2.1.1 The organisation provides its personnel with occupational health services.

5.2.1.2 Where applicable, legislation regarding occupational health services is implemented.

5.2.1.3 The organisation has access to the services of a knowledgeable and experienced person in the field of occupational health.

5.2.1.4 Written policies and procedures on all aspects of health and safety guide personnel in maintaining a safe work environment.

5.2.1.5 The occupational health service provides information and training on risks specific to the healthcare workers.

5.2.1.6 First aid kits/materials for healthcare workers are available.

5.2.1.7 Post exposure prophylaxis (PEP) is available to personnel in accordance with organisational policy.

5.3 Security

5.3.1 As part of risk management, the organisation makes provision for the safety and security of personnel, volunteers, patients, visitors and buildings.

STANDARD INTENT:

The organisation has a responsibility to ensure that personnel, volunteers, patients and visitors are safe from attacks or theft by intruders. The organisation identifies areas and groups that are vulnerable and require added security.

The healthcare facility takes responsibility for protecting patients from physical assault by outsiders, other patients and personnel. This responsibility is particularly relevant to infants and vulnerable children, the elderly and others unable to protect themselves or signal for help. Each healthcare facility identifies its vulnerable patient groups and establishes a process for protecting the rights of individuals in those groups. Vulnerable patient groups and the healthcare facility's responsibility may be identified in Namibian laws, charters or regulations. Comatose patients and patients with mental or emotional disabilities are also included. Protection extends beyond preventing physical assault to other areas of safety. Verbal and other forms of abuse, negligent care, withholding health facilities and failing to provide assistance in the event of a fire or other emergency are all aspects of safety and require vigilance.

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

Personnel understand their responsibilities in these processes.

Plans are developed and implemented to provide protection. The loss of organisation property must be prevented.

CRITERIA:

5.3.1.1 Security systems provide for internal security.

5.3.1.2 There is effective control of access to restricted areas in the facility, e.g. laboratory, pharmacy, etc.

5.3.1.3 Security systems provide for external security.

5.3.1.4 The healthcare facility has a process for protecting patients and personnel from assault.

5.3.1.5 A mechanism, known to personnel, is available for summoning the assistance of security/police/protection service in the case of an emergency.

5.3.1.6 Alarm systems and signals are tested every month.

5.4 Fire safety

5.4.1 As part of risk management, the organisation implements structured systems to ensure fire safety.

STANDARD INTENT:

Fire is an ever-present risk in a healthcare organisation. An organisation needs to plan for:

- The prevention of fires through the reduction of risks, such as the safe storage and handling of potentially flammable materials
- Safe and unobstructed means of exit in the event of fire
- Clearly depicted fire escape routes
- Inspection reports from the local fire departments
- Suppression mechanisms such as water hoses, chemical suppressants or sprinkler systems

These actions, when combined, give patients, families, personnel and visitors adequate time to exit the facility safely in the event of a fire or smoke. These actions are effective no matter what the age, size or construction of the facility.

The organisation's fire safety plan identifies:

- The frequency of inspection, testing and maintenance of fire protection and safety systems, consistent with requirements
- The process for testing the plan for the safe evacuation of the facility in the event of a fire or smoke at least twice per year
- The necessary education of personnel to protect and evacuate patients effectively when an emergency occurs
- The need for each personnel member to participate in at least one emergency preparedness test per year
- The required documentation of all inspection, testing and maintenance systems

The organisation develops and implements a policy and plan to eliminate smoking in the organisation's facilities or to limit smoking to designated non-patient care areas.

CRITERIA:

5.4.1.1 There are structured systems and processes in place to ensure that all occupants of the organisation's facilities are safe from fire or smoke.

5.4.1.2 Documented certification is available from the relevant authority to show that the facility complies with applicable laws and regulations in relation to fire safety (e.g. fire clearance certificate).

5.4.1.3 Fire-fighting equipment is regularly inspected and serviced at least annually and the date of the service is recorded on the apparatus.

5.4.1.4 Flammable materials are clearly labelled and safely stored.

5.4.1.5 Easily recognised and understood signs prohibiting smoking are displayed in areas where flammable materials and combustible gases are stored.

5.4.1.6 A floor plan, showing the location of fire-fighting equipment, electrical distribution boards, evacuation routes and emergency exits, is displayed.

5.4.1.7 Annual personnel training in fire prevention and evacuation procedures is documented.

5.5 Emergency planning

5.5.1 As part of risk management, the organisation develops a written plan to respond to emergencies.

STANDARD INTENT:

Community emergencies, epidemics and disasters, such as damage to patient care areas as a result of an earthquake or flu epidemics that affects personnel, may directly involve the organisation. Organisations should also be prepared for bomb threats, fire, flooding, natural disasters, failure of water and electrical supplies, hostage taking, explosions and the consequent loss of vital services.

There may be a time when it is necessary to evacuate patients. This can only be done quickly and effectively if personnel are trained in evacuation procedures.

To respond effectively, the organisation develops a plan and tests it. The plan provides processes for alternate care sites, if needed, and alternate sources of medical supplies, communication equipment and other materials, such as food and water, if an inpatient unit or day care centre exists on the premises.

CRITERIA:

5.5.1.1 There is a written plan to deal with emergencies (including bomb threats, fire, flooding, natural disasters, failure of water and electrical supplies).

5.5.1.2 Documented evidence is available to show that personnel participate in a rehearsal of the plan at least annually.

5.6 Prevention and control of infections

5.6.1 As part of risk management, the organisation designs and implements a coordinated programme to reduce the risk of infections in patients and healthcare workers.

STANDARD INTENT:

For an infection prevention and control programme to be effective it must be comprehensive, encompassing both patient care and employee health. The programme is appropriate to the size and geographic location of the organisation, the services offered by the organisation and the patients seen by the organisation.

Infections can enter the organisation via patients, their families, personnel, volunteers, visitors, other individuals and vectors. All areas of the organisation where these individuals or vectors are found must therefore be included in the programme of infection surveillance, prevention and control.

One or more individuals, acting on a full-time or part-time basis, direct the programme. The qualifications needed depend on the activities they will carry out and the requirements may be met through education, training or experience. Coordination involves communication with all parts of the organisation to ensure that the programme is continuous and proactive.

Whatever the mechanism chosen by the organisation to coordinate the infection control programme, medical and nursing personnel are represented and engaged in the activities. The individual, committee or other mechanism must also monitor those housekeeping and other support service practices which may lead to the spread of infection, for example, cleaning, linen supply, laundry services and waste disposal.

Information is essential to an infection control programme as it supports the following activities:

- Tracking risks, rates and trends in nosocomial infections
- Data analysis
- Interpreting and presenting findings

In addition, infection control programme data and information are managed with those of the organisation's quality management and improvement programme.

Hand washing, barrier techniques and disinfecting agents are fundamental to infection prevention and control. The organisation identifies those situations in which the use of masks and gloves is required and provides training in their correct use. Soap and disinfectants are placed in those areas where hand washing and disinfecting procedures are required. Personnel are educated in proper hand washing and disinfecting procedures.

CRITERIA:

5.6.1.1 An individual personnel member is identified to be responsible for infection control in the organisation.

5.6.1.2 All patient, personnel and visitor areas of the facility are included in the documented infection control programme.

5.6.1.3 Written policies and procedures guide personnel in the implementation of the infection control programme.

5.6.1.4 Regular in-service training is given to all personnel in the field of infection control and is documented.

5.6.1.5 The infection control programme is monitored through a document audit process.

5.6.1.6 Hand washing and disinfecting facilities, including water, soap, paper towels or hand sanitisers are available in all relevant areas.

5.6.1.7 Personnel are constantly reminded of the importance of effective hand washing, e.g. posters are displayed.

5.6.1.8 Protective clothing (gloves, masks, aprons etc.) are available and used correctly.

5.6.1.9 The organisation uses risk, rate and trend information to design or modify processes to reduce healthcare associated infections to the lowest possible levels.

5.6.1.10 The organisation reports information on healthcare associated infections and notifiable diseases to appropriate external public health agencies.

5.6.2 The organisation has a written plan for handling, storing and disposing of waste.

STANDARD INTENT:

Household waste, hazardous waste, such as chemicals, hazardous gases and vapours, pharmaceutical and healthcare waste, are identified by the organisation and are safely controlled according to a plan. All clinical waste is regarded as hazardous or potentially hazardous. The plan is included in the organisation's risk management plan.

CRITERIA:

5.6.2.1 Waste is managed according to a written plan, consistent with current local bylaws and regulations.

5.6.2.2 The plan includes safe handling, storing and disposing of different types of waste.

5.6.2.3 Handling, storing and disposing of healthcare waste is included in the plan.

5.6.2.4 There is a colour coding system for the bags to be used for segregating the different types of waste.

CARE OF PATIENTS

6. PRIMARY HEALTH CARE SERVICES

OVERVIEW OF PRIMARY HEALTH CARE SERVICES:

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up. Many medical, nursing, pharmaceutical, rehabilitative and other types of healthcare providers may carry out these activities. Each provider has a clear role in patient care. The patient, his/her family or other trained caregivers may carry out some of this care.

A plan for each patient is based on an assessment of needs. That care may be preventive, palliative, curative or rehabilitative and may include the use of medication, supportive therapies or a combination of these approaches. A patient's illness or physical condition may require early attention and should be "fast tracked" to prevent a long wait in the queue. Policies describing the recognition of such patients are available and procedures are in place to expedite prompt treatment.

It is essential that assessments are well documented and can be easily retrieved from the patient's record. As part of assessing patient care needs, diagnostic tests may be required. The healthcare facility has access to laboratory or radiography services. These facilities are available within an appropriate time frame.

A healthcare facility should be able to provide some form of emergency care, depending on its mission and resources and the needs of the community. Some patients may present at the healthcare facility with respiratory or cardiac distress while others may respond adversely to medication administered at the healthcare facility. Survival depends on, inter alia, the early recognition of cardiopulmonary arrest, early activation of trained responders, early cardiopulmonary resuscitation and early defibrillation, when indicated. The level of emergency care and resuscitation to be provided must be clearly defined in written documents. Those items of equipment deemed to be necessary for resuscitation are listed and regular equipment checks are carried out. Individuals in patient care areas are responsible for checking resuscitation equipment every day or after each use, whichever comes first. Records of these tests are maintained. Resuscitation equipment is accessible within one minute in all patient care areas.

Guidelines are available for the assessment and treatment of patients for each programme. National Standardised Treatment Guidelines (NSTG) or equivalents are provided by Namibia’s Ministry of Health and Social Services. Guidelines provide a means of improving quality and assist practitioners and patients in making healthcare decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and healthcare facility pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the healthcare facility leaders and healthcare facility practitioners before implementation. This ensures that they meet the criteria established by those leaders and are adapted to the community, patient needs and healthcare facility resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

Every patient is offered the education he or she requires. All personnel within the healthcare facility work collaboratively to provide education in a coordinated manner. Education is focused on the specific knowledge and skills the patient and his/her family will need to make decisions about care, participate in care and continue care at home. Variables like educational literacy, beliefs and limitations are considered. Each healthcare facility decides on the placement and format of educational assessment, planning and delivery of information in the patient's record. Education in areas that carry high risk to patients is routinely provided by the healthcare facility. Standardised materials and processes are used where possible.

Learning occurs when attention is paid to the methods used to educate patients and their families. The healthcare facility selects appropriate educational methods and people to provide the education. Personnel collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible. Information provided by the healthcare facility

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

STANDARDS

6.1 Organisation and coordination

6.1.1 The service is organised to provide a safe and effective service and is coordinated with other relevant services in the referral hospital and in the community.

CRITERIA:

6.1.1.1 The lines of communication between the healthcare facility, referral hospital and community services are clearly defined.

6.1.1.2 Relations are established, and contact is maintained with other relevant services and agencies, including both governmental and non-governmental agencies.

6.1.1.3 An on-call roster is available for after hour, weekend and holidays emergency coverage (e.g. for infectious diseases).

6.1.1.4 There is an organised process for referring patients.

6.1.1.5 Radiology services are available for the level of care provided.

6.1.1.6 Laboratory services are available for the level of care provided.

6.1.1.7 Ultrasound services are available for the level of care provided.

6.2 Facilities and equipment

6.2.1 The required furniture and equipment are available and functioning appropriately.

STANDARD INTENT:

In order to provide safe patient care, each unit requires adequate resources. The building is appropriate for a healthcare facility in terms of size and layout. There is a separate room for the handover between shifts, writing of reports and nurse meetings.

An assessment is made as to whether the facility has the required furniture and equipment. Facilities will be required to complete an inventory of their furniture and equipment based on the standard lists and to report the percentage of total items they have in stock relative to the total recommended.

The physical facilities required include adequate office accommodation for personnel. Cleaning equipment is safely stored in a room or cupboard, used expressly for this purpose. Toilet facilities are adequate for patients and personnel. Lighting and ventilation meet the needs of each area in the facility.

CRITERIA:

6.2.1.1 Patient and personnel accommodation in the outpatient service is adequate for personnel to provide patient care.

6.2.1.2 The lay-out of the facility allows for effective flow of patient care.

6.2.1.3 The required furniture and equipment is available in accordance with established lists and is functioning properly.

6.2.1.4 Stretchers and wheelchairs are available and are functioning properly.

6.2.1.5 Oxygen supplies (oxygen cylinders or air enrichers) meet the patient needs.

6.2.1.6 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are constantly monitored while patients are receiving oxygen.

6.2.1.7 Oxygen cylinders are stored in accordance with local safety standards.

6.2.1.8 Suction supplies meet the patient care needs.

6.2.1.9 There is a separate room for personnel to handover between shifts, write reports, hold meetings, etc.

6.2.1.10 Separate sanitary facilities are provided for personnel.

6.2.1.11 Hand washing facilities, including water, soap and paper towels, are available.

6.2.1.12 Out Patient facilities and waiting rooms are clean, well ventilated, well maintained and ensure privacy.

6.2.1.13 Consultation rooms are clean, well ventilated, well maintained and adequately equipped.

6.3 Assessment of patients

6.3.1 The initial assessment of patients takes place at the point of first contact to ensure that their needs are met.

STANDARD INTENT:

Matching patient needs to the healthcare facility's mission and resources depends on obtaining information on the patient's needs and condition through screening at the first point of contact. The screening assessment leads to an understanding of the type of preventive, palliative, curative and rehabilitative services needed by the patient. This information is used to determine the most appropriate setting(s) required to meet the patient's most urgent needs. Admission to the healthcare facility and/or referral to another setting may be required to meet the patient's needs.

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

- Determine the patient's needs
- Determine whether the healthcare facility has the appropriate resources to treat the patient
- Establish whether the patient should be referred or transferred to another setting for care

CRITERIA:

6.3.1.1 There is a system, which includes patient identification, for initiating screening at the point of first contact.

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

6.3.1.3 There is a system for ensuring that patients are seen within the shortest possible time.

6.3.1.4 Patients who require early attention are identified (e.g. the very frail or ill, or women in an advanced stage of pregnancy).

6.3.1.5 There is a system for "fast tracking" patients requiring early attention.

6.3.1.6 Waiting times are monitored as part of the organisation's quality management and improvement programme and kept to the minimum.

6.3.2 All patients cared for by the healthcare facility have their healthcare needs identified through a comprehensive assessment process.

STANDARD INTENT:

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

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

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

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

CRITERIA:

6.3.2.1 Policies and procedures for assessing patients on arrival and during ongoing care are implemented.

6.3.2.2 Written procedures ensure that assessments are performed within appropriate time frames.

6.3.2.3 Patient assessments are conducted by personnel who have been identified as competent to do so.

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

6.3.2.5 Current clinical guidelines relevant to the organisation's patients and services are used to standardise care processes.

6.4 Emergency care

6.4.1 The healthcare facility provides emergency treatment and care.

CRITERIA:

6.4.1.1 Written guidelines for providing primary emergency services are available and are followed.

6.4.1.2 Guidelines for paediatric emergency triage, assessment and treatment (ETAT) are available and are followed.

6.4.1.3 Information on cases and the outcome of emergency treatment are recorded in a register/logbook.

6.4.1.4 Case reviews are undertaken to assess the quality of treatment and care of patients requiring emergency care.

6.4.1.5 The service is organised in terms of personnel, facilities, equipment and procedures to evaluate, manage, stabilise and transfer patients with emergency conditions.

6.4.2 The healthcare facility provides resuscitation in accordance with organisational policy.

CRITERIA:

6.4.2.1 The healthcare facility has a policy on resuscitation which includes the level at which resuscitation is provided, by whom and training and equipment requirements.

6.4.2.2 The availability of resuscitation equipment and medication with clear instructions for use is specified in the organisation's policy on resuscitation.

6.4.2.3 Personnel are trained in resuscitation and records are kept of their attendance at such training.

6.4.2.4 Equipment for early cardiopulmonary resuscitation is available within one minute in each area of the facility.

6.4.2.5 Equipment for early cardiopulmonary resuscitation includes at least a CPR board, oral airways, an Ambu bag or equivalent, endotracheal tubes and laryngoscopes.

6.4.2.6 Where early defibrillation is indicated, there is a defibrillator with an ECG component.

6.4.2.7 The resuscitation equipment is available in adult and paediatric sizes.

6.4.2.8 There is a drug tray or trolley with appropriate facilities for intravenous therapy, insertion of nasogastric tubing and drug administration (including paediatric sizes).

6.4.2.9 The drugs available in accordance with a specified list, include those for cardiac and respiratory arrest, coma, fits and states of shock (including paediatric doses) and plasma expanders.

6.4.2.10 A designated person checks and documents that resuscitation equipment and drugs are checked every day, or immediately after use (whichever is the sooner), by those who have been given this responsibility.

6.4.2.11 Records of these checks are kept, with reports on problems experienced, advice given and any remedial action taken.

6.4.3 The healthcare facility provides ambulance/emergency medical services.

STANDARD INTENT:

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

CRITERIA:

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

6.4.3.2 There is an effective system for facilitating communication between personnel of the healthcare facility, the ambulance service and the receiving organisations.

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

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

6.4.3.5 Medical transport/ambulance vehicles are clean.

6.4.3.6 The ambulances are fully equipped to deal with obstetric emergencies.

6.5 Continuity of care

6.5.1 There are mechanisms for holding patients for observation.

CRITERIA:

6.5.1.1 Policies and procedures for holding patients for observation are implemented.

6.5.1.2 Bedside facilities (bedside table/locker, chair/bench) are available.

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

6.5.1.4 Each bed space is provided with adequate lighting.

6.5.1.5 Ward screens are available to ensure privacy.

6.5.1.6 Patients have access to ablution facilities.

6.5.1.7 Processes are implemented to provide patients with access to food and water.

6.5.1.8 Personnel are allocated to record regular observations of the patient's condition.

6.5.2 The healthcare facility designs and carries out processes for providing continuity of patient care services.

CRITERIA:

6.5.2.1 Arrangements are in place to ensure that adequate referral services are available.

6.5.2.2 Referrals outside the facility are to specific individuals and/or agencies in the patient's home community wherever possible.

6.5.2.3 There are written guidelines for referring emergency patients.

6.5.2.4 Patients and, as appropriate their families, are given follow-up instructions, which are provided in an understandable form and manner.

6.5.2.5 A copy of the referral letter is available in the patient's record.

6.6 Reproductive health

6.6.1 A contraceptive service is provided to meet the needs of families in the community.

STANDARD INTENT:

Every patient is offered access to contraceptive services and education on reproductive health. All personnel are trained to recognise and meet the specific needs of adolescents and youth. All personnel in the healthcare facility work collaboratively to provide education in a coordinated manner. Education is focused on the specific knowledge and skills the patient will need to make decisions on the use of contraceptive methods. Variables like educational literacy, beliefs and limitations are taken into account. Standardised materials and processes are used where possible. Data is collected (for example, logbook), analysed and used to provide relevant information for improving the service, for example, the number of contraceptives/condoms used per month.

CRITERIA:

6.6.1.1 Guidelines for providing contraceptive services are available and are followed.

6.6.1.2 Personnel show evidence of education for and competence in providing a contraceptive service.

6.6.1.3 A range of most frequently prescribed contraceptive methods is provided, including injectable hormonal contraceptives, oral hormonal contraceptives, barrier methods and emergency contraceptives.

6.6.1.4 Personnel who are authorised to insert intra-uterine contraceptive devices show evidence of current training and competence in the procedure.

6.6.1.5 A record of the chosen method for each patient is available.

6.6.1.6 Guidelines regarding the advice to be given to patients on sterilisation are available and are followed.

6.6.1.7 Guidelines regarding the advice to be given to patients on termination of pregnancy (TOP) are available and are followed.

6.6.1.8 Guidelines for administering post-coital contraceptives are available and are followed.

6.6.1.9 Condoms are freely available from strategically placed condom dispensers.

6.6.1.10 Guidelines for Post Exposure Prophylaxis (PEP) in the case of sexual violence are available and are followed.

6.6.2 An effective antenatal service is provided.

STANDARD INTENT:

A plan for each patient is based on an assessment of needs. The organisation defines, in writing, the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations.

These findings will include the diagnosis of pregnancy and the measurements during follow up which may include weight, blood pressure, oedema, protein in urine, fever and activity of the foetus. It is essential that assessments are well documented and can be easily retrieved from the patient's record. The frequency of follow-up visits should be clearly indicated. Namibian clinical guidelines and protocols are available to ensure up-to-date treatment of complications during pregnancies and side effects of treatment with regard to the foetus. National guidelines must be used if available.

CRITERIA:

6.6.2.1 Guidelines for routine tests, observations and examinations to be conducted on pregnant women are available and are followed.

6.6.2.2 Personnel show evidence of education and competence in the provision of antenatal care.

6.6.2.3 Policies cover the screening for syphilis and treatment according to the result.

6.6.2.4 All tests, observations and examinations are recorded.

6.6.2.5 Guidelines for referring patients with complicated pregnancies to specialist services are available and are followed.

6.6.2.6 Guidelines for educating pregnant women in preparation for breast feeding are available and are followed.

6.6.2.7 Guidelines for caring for HIV-positive obstetric patients are available and are followed.

6.6.3 Where midwifery services are provided, there are adequate resources to ensure safe and effective care.

CRITERIA:

6.6.3.1 Guidelines for the provision of midwifery services are available and are followed.

6.6.3.2 Guidelines (such as Emergency Obstetric and Neonatal Care) are used to reduce the number of maternal deaths in the labour ward.

6.6.3.3 A registered/professional nurse with midwife training/experience is present at every birth.

6.6.3.4 At least one person who is competent in the management of maternal and neonatal emergencies is available for consultation at all times.

6.6.3.5 Guidelines for managing labour are available and are followed.

6.6.3.6 Observations during labour are recorded on a partograph.

6.6.3.7 Guidelines for the active management of the third stage of labour, including postpartum bleeding are available and are followed.

6.6.3.8 There is a system for disposing of placentas safely.

6.6.3.9 Information on cases and the outcome of deliveries are recorded in a register/log book.

6.6.3.10 There is an established process for conducting vacuum extractions or for referring patients who need vacuum extractions.

6.6.3.11 There is an established process for conducting Caesarean sections or for referring patients who need Caesarean sections.

6.6.4 Equipment for delivering babies is safe and adequate.

CRITERIA:

6.6.4.1 There is a delivery room with adequate lighting, including an angle poise lamp, and ventilation.

6.6.4.2 The delivery room is furnished with a suitably positioned delivery table, which allows for use in the Trendelenburg or lithotomy positions.

6.6.4.3 Standard surgical/obstetric equipment is supplied in accordance with an approved list.

6.6.5 An effective post-delivery neonatal service is provided.

CRITERIA:

6.6.5.1 Guidelines for neonatal resuscitation are available and are followed.

6.6.5.2 Resuscitation equipment is available, including suction apparatus, oxygen, paediatric manual ventilator (Ambu-bag) and masks for new-borns.

6.6.5.3 Standard neonatal equipment is supplied in accordance with an approved list.

6.6.5.4 An Apgar rating is recorded for each new-born baby.

6.6.5.5 Policies and procedures guide the identification of new-born babies.

6.6.5.6 There are established security systems for protecting new-born babies.

6.6.5.7 There is an established programme for vaccinating new-born babies following delivery and prior to discharge.

6.6.6 An effective postnatal service is provided.

CRITERIA:

6.6.6.1 Guidelines for post-natal care are available and are followed.

6.6.6.2 Personnel show evidence of education and competence in providing post-natal care.

6.6.6.3 All tests, observations and examinations are recorded.

6.6.6.4 Guidelines for referring patients with post-natal complications to specialist services are available and are followed.

6.6.6.5 Policies address the issues of breastfeeding (transmission risk) and its alternatives and the provision of breast milk substitutes in accordance with guidelines.

6.6.6.6 Policies address the follow-up testing of infants born to mothers with HIV infection in accordance with guidelines.

6.7 Child health

6.7.1 The healthcare facility provides immunisation in accordance with National Guidelines.

CRITERIA:

6.7.1.1 Guidelines for providing an immunisation programme are available and are followed.

6.7.1.2 The facility manager reviews the coverage and practice of immunisation, the vaccine supply and maintenance of the cold chain.

6.7.1.3 Guidelines for immunising HIV-positive children are implemented.

6.7.2 Services are provided to promote the health and growth of children.

CRITERIA:

6.7.2.1 Guidelines for measuring the growth and development of children and referring them appropriately where growth or development are delayed and the Integrated Management of Childhood Illnesses (IMCI) manual are available and are followed.

6.7.2.2 The child health chart is completed after each visit.

6.7.2.3 Guidelines for hearing tests for children are available and are followed.

6.7.2.4 A programme promoting breastfeeding is followed.

6.7.2.5 Children with nutritional deficiency disorders are identified, managed or appropriately referred.

6.7.2.6 There is an oral rehydration service, which includes counselling.

6.7.2.7 The healthcare facility is adolescent- and youth-friendly, and meets the specific healthcare needs of these groups in accordance with national guidelines.

6.8 Communicable disease management

6.8.1 There is a programme for preventing and treating diarrhoeal diseases.

CRITERIA:

6.8.1.1 Guidelines for preventing and treating diarrhoeal infections are available and are followed.

6.8.1.2 There are protocols for stool collection, where appropriate.

6.8.1.3 There are guidelines and resources for treating dehydration.

6.8.2 There is a programme for preventing and treating sexually transmitted infections.

CRITERIA:

6.8.2.1 Guidelines for managing sexually transmitted infections are available and are followed.

6.8.2.2 Guidelines relating to syphilis serology results are available and are followed.

6.8.2.3 There is a policy on the tracing of partners/contacts of patients with sexually transmitted infections (STIs).

6.8.2.4 Provider initiated testing and counselling (PITC) is performed according to set methodologies defined in prevailing guidelines.

6.8.3 There is a programme for preventing and treating tuberculosis.

CRITERIA:

6.8.3.1 There is a system for sputum microscopy.

6.8.3.2 The outcomes of sputum testing are monitored.

6.8.3.3 Tuberculosis (TB) treatment accords with current guidelines.

6.8.3.4 There is an uninterrupted supply of medication for TB treatment.

6.8.3.5 The facility has a TB infection control management plan that is implemented.

6.8.3.6 The principles of directly observed treatment are adhered to.

6.8.3.7 Policies and procedures relate to community support of the directly observed TB treatment and are implemented.

6.8.3.8 Supporters (community or family) of the directly observed TB treatment are provided with appropriate training.

6.8.3.9 Patients with positive tuberculosis test results are counselled and provided with HIV testing.

6.8.3.10 Provider initiated testing and counselling (PITC) is carried out according to set methodologies defined in prevailing guidelines.

6.8.4 There is a programme for preventing and treating malaria.

CRITERIA:

6.8.4.1 Malaria treatment accords with current guidelines.

6.8.4.2 There is a system for testing for malaria.

6.8.4.3 There is an uninterrupted supply of medication for the treatment of Malaria.

6.8.4.4 Oral and intravenous medication for malaria treatment is available.

6.8.4.5 There is a mechanism for referring patients with complications of malaria.

6.9 HIV infection and AIDS management

6.9.1 Management of HIV infection and AIDS accords with approved guidelines.

CRITERIA:

6.9.1.1 Guidelines for preventing, caring for and treating patients with HIV infection and AIDS are available and are followed.

6.9.1.2 There is a monitoring system that complies with national reporting requirements.

6.9.1.3 Facility infrastructure and equipment for the implementation of Voluntary Counselling and Testing (VCT) are present and available.

6.9.1.4 Voluntary counselling and testing (VCT) is performed according to set methodologies defined in prevailing guidelines.

6.9.1.5 Provider initiated testing and counselling (PITC) is carried out according to set methodologies defined in prevailing guidelines.

6.9.1.6 VCT and/or PITC results are available on the day of testing.

6.9.1.7 There is an established system for encouraging partner notification.

6.9.1.8 Antiretroviral therapy (ART) is administered in accordance with prevailing guidelines.

6.10 Cancer screening

6.10.1 A cancer screening and prevention programme is available.

CRITERIA:

6.10.1.1 Guidelines for providing breast and cervical cancer prevention programmes are available and are followed.

6.10.1.2 There are policies and procedures for the taking of Papanicolaou (Pap) smears and dealing with the results.

6.11 Care for non-communicable chronic diseases

6.11.1 The healthcare facility provides general primary care.

CRITERIA:

6.11.1.1 Guidelines for assessing and treating patients with chronic non-communicable diseases (e.g. hypertension, diabetes, cardiovascular, etc.) are available and are followed.

6.11.1.2 Appropriate equipment is available for conducting the assessments.

6.11.1.3 Patients are provided with the necessary aids, as appropriate to their needs.

6.11.1.4 Equipment and materials for the provision of wound care are provided.

6.11.1.5 Wound care procedures/guidelines/standard operating procedures (SOP) are available and are followed.

6.11.2 The healthcare facility provides care and treatment for mental disorders, within its capabilities.

CRITERIA:

6.11.2.1 Guidelines, including mental health legislation, for assessing and treating patients attending the mental health service are available and are followed.

6.11.2.2 There is access to mental health expertise, when required (a psychiatrist or psychologist, as appropriate).

6.11.3 The healthcare facility provides preventive and promotive programmes for oral health, and curative dental services as appropriate to meet the needs of the community.

CRITERIA:

6.11.3.1 Guidelines for oral health assessment, education and treatment are available and are followed.

6.11.3.2 Where there is an oral hygienist, he/she is competent to conduct oral examinations and to provide oral hygiene in accordance with current documented guidelines.

6.11.3.3 There is a dental roster to ensure that dental personnel are available at all times, either on call or on the premises.

6.11.3.4 Dental practitioners have the necessary equipment to ensure that the procedures performed are undertaken safely and competently.

6.11.3.5 Where radiographic equipment is used, this conforms with the Ionising Radiation's regulations.

6.11.3.6 Appropriate shielding and protective clothing is worn in the presence of biohazards or radiographic equipment which conforms with the Ionising radiation's regulations.

6.11.3.7 Medication is available for dental use.

6.11.3.8 Materials are available for local anaesthesia.

6.11.3.9 The dental service works with the infection control personnel in the healthcare facility to ensure that infection control policies and procedures are implemented.

6.12 Community-based home care

6.12.1 Caregivers identify the needs of patients for home care.

STANDARD INTENT:

The World Health Organisation (WHO) defines home care "as the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health including care towards a dignified death. Home care services can be classified into preventive, promotive, therapeutic, rehabilitative, long-term maintenance and palliative care categories."

Generally, home care is provided by carers from the community, supervised by professional nurses from governmental organisations or NGOs.

CRITERIA:

6.12.1.1 Each patient referred for home care has a full assessment to identify his/her needs for home care.

6.12.1.2 Personnel, transport and resources are available to provide the service.

6.12.1.3 Homecare records are kept for each patient and include the type of care, medication and services provided.

7. INPATIENT CARE

OVERVIEW OF INPATIENT CARE:

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

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

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

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

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

Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services.

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

STANDARDS

7.1 Management of the service

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

STANDARD INTENT

The individuals who bear overall responsibility for the patient's care or for a particular phase of care are identified in the patient's record or in a manner that is made known to personnel. Those responsible for the patient's care include medical practitioners, nurses, members of professions allied to medicine, for example, physiotherapy, etc.

CRITERIA:

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

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

7.1.2 The delivery of services is integrated and coordinated amongst care providers.

STANDARD INTENT:

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

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

CRITERIA:

7.1.2.1 There is a regular schedule of ward rounds with medical personnel.

7.1.2.2 Information exchanged includes a summary of the care provided.

7.1.2.3 Information exchanged includes patient response to treatment.

7.2 Facilities and equipment

7.2.1 Adequate facilities are available for providing safe care to patients in the ward.

STANDARD INTENT:

To provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used expressly for this purpose.

There are adequate toilet and bathing facilities for the number of patients in the ward. There is adequate lighting and ventilation. Emergency call systems are available at bedsides and in bathrooms and toilets. The emergency call system is connected to the emergency power system.

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

Resuscitation equipment is immediately accessible from each section of the ward.

Where midwifery services are provided, each delivery room has:

- At least one cardiotocograph machine
- An infant warming and resuscitation cart
- An incubator with adjustable temperature and separate oxygen supply • A foetal monitor
- Equipment for inhalation analgesia
- A suction machine

CRITERIA:

7.2.1.1 Patient and personnel accommodation in the service is adequate to meet patient care needs.

7.2.1.2 Oxygen supplies (oxygen cylinders or air enrichers) meet the patient care needs.

7.2.1.3 Suction supplies meet the patient care needs.

7.2.1.4 Where there are no piped oxygen installations, there is a documented procedure for ensuring that cylinder pressures (i.e. contents) are constantly monitored while patients are receiving oxygen.

7.2.1.5 There is a dedicated area in the ward kitchen for preparing infant feeds, where applicable.

7.2.1.6 There is a separate room for personnel to hand over between shifts, write reports, hold meetings etc.

7.2.1.7 Separate sanitary facilities are provided for personnel.

7.2.1.8 Separate ablution facilities are available in the ward for the patients.

7.2.1.9 There is a separate scullery/sluice room for patients' eliminations, waste and laundry.

7.2.2 Adequate resources are available for providing safe care to patients in the ward.

CRITERIA:

7.2.2.1 Bed devices (frames/cot-sides, cradles, bed blocks, etc.) are available and functional.

7.2.2.2 Bedside facilities (bedside table/locker, chair/bench) are available.

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

7.2.2.4 Each bed space is provided with adequate lighting.

7.2.2.5 Ward screens are available to ensure privacy.

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

7.2.2.7 Equipment and materials are provided for the patients' personal hygiene.

7.2.2.8 Mattresses, bed linen, towels and pyjamas for patients are available and in good condition.

7.2.2.9 Equipment and materials for facilitating patients' mobility are available and in good condition.

7.2.2.10 Equipment and materials for monitoring patients' vital signs are provided.

7.2.2.11 Equipment and materials for wound care and treating fractures are provided.

7.3 Policies, procedures and Clinical Practice Guidelines

7.3.1 Policies and procedures/SOPs guide the care of patients and the provision of services.

STANDARD INTENT:

Policies and procedures are important to help personnel understand the facility's patients and services and to respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the needs of the patients and the services to be provided. They use a collaborative process to develop policies and procedures and to train personnel in their implementation.

It is particularly important that the policies or procedures indicate:

- How planning will occur
- The documentation required for the care team to work effectively
- Special consent considerations
- Monitoring requirements
- Special qualifications or skills of personnel involved in the care process
- The availability and use of resuscitation equipment, including equipment for children

Clinical guidelines are frequently helpful and may be incorporated in the process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on high risk patients and procedures, for example:

- The care of emergency patients
- The handling, use and administration of blood and blood products
- The management of contaminated blood supplies (expired, opened or damaged containers)
- The care of patients with communicable diseases
- The care of immuno-suppressed patients
- The use of restraint and the care of patients in restraint
- The care of frail, dependent elderly patients
- The care of young, dependent children
- The security of new-born babies

CRITERIA:

7.3.1.1 Policies and procedures for nursing care are available and are followed as indicated in the statement of intent above.

7.3.1.2 Nurses use performance checklists/protocols/guidelines for complex skills, e.g. intravenous infusions, catheterisation, nasogastric intubation.

7.3.1.3 Personnel are trained and use the policies and procedures to guide care.

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

STANDARD INTENT:

Clinical Practice guidelines provide a means to improve quality and assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names including practice parameters, practice guidelines, patient care protocols and standards of practice. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the organisation's leaders and clinical practitioners before implementation. This ensures that the guidelines meet the criteria established by the leaders and are adapted to the community, patient needs and the resources of the organisation. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

CRITERIA:

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

7.3.2.2 Guidelines are used in clinical monitoring as part of a structured clinical audit.

7.3.2.3 Guidelines are reviewed and adapted on a regular basis after implementation.

7.4 Patient care

7.4.1 The patient needs identified in the care plan are addressed.

STANDARD INTENT:

A single, integrated plan is preferable to the entry of a separate care plan by each provider. Collaborative care and treatment team meetings or similar patient discussions are recorded. Individuals who order diagnostic and other procedures are qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and execution of orders.

An organisation decides:

- Which orders must be written rather than verbal
- Who is permitted to write orders
- Where orders are to be located in the patient record

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

When guidelines and other related tools are available and relevant to the patient population and mission of the organisation, there is a process for evaluating and adapting them to the needs and resources of the organisation and for training personnel to use them.

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent, for example, verbally, by signing a consent form or through some other mechanism. Patients and families understand who may, in addition to the patient, give consent. Designated personnel are trained to inform patients and to obtain and document patient consent. Personnel clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. Informed consent includes:

- An explanation of the risks and benefits of the planned procedure
- Identification of potential complications
- Consideration of the surgical and non-surgical options available to treat the patient

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

The organisation lists all those procedures that require informed written consent. Leaders document the processes for obtaining informed consent. The consent process always concludes with the patient signing the consent form or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledged full understanding of the information. The patient's surgeon or other qualified individual provides the necessary information and the name of this person appears on the consent form.

CRITERIA:

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

7.4.1.2 There is documented evidence that patients' vital signs are monitored, registered and interpreted according to a regular daily schedule.

7.4.1.3 Procedures for the elimination of patients' secretions are implemented.

7.4.1.4 Wound care procedures/guidelines/standard operating procedures (SOP) are available and are followed.

7.4.1.5 Wound dressings are inspected daily and where indicated the wound is inspected.

7.4.1.6 When indicated, the dressing is changed.

7.4.1.7 Measures are in place to prevent immobility and prevent the complications of immobility.

7.4.1.8 There is evidence that the patient is encouraged to become active and to use aid appliances, where necessary, to stimulate the rehabilitation process.

7.4.1.9 There is evidence that the patient, when confined to bed or immobile, receives assistance with lifting, moving, positioning, turning in bed and transferring from and back to bed.

7.4.1.10 There is evidence that pressure relieving techniques (care of skin, turning in bed on schedule, observing and preventing potential bedsores) are implemented and documented.

7.4.1.11 Patients receive professional physiotherapy care and assistance with rehabilitation if required.

7.4.2 Compassionate care is provided to patients in pain and to the dying.

STANDARD INTENT:

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

- Identifying patients with pain during initial assessment and reassessment
- Communicating with and providing education for patients and families about pain management in the context of their personal, cultural and religious beliefs

- Educating healthcare providers in pain assessment and management

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

CRITERIA:

7.4.2.1 The organisation implements processes for addressing the patient's needs for appropriate assessment and management of pain.

7.4.2.2 The organisation educates health professionals in assessing and managing pain.

7.4.2.3 Policies and procedures regarding the care of dying and deceased patients are implemented.

7.5 Surgical services

7.5.1 Based on the results of the assessment, each patient's surgical care is planned and documented.

CRITERIA:

7.5.1.1 Medical assessments are carried out and documented before patients go to surgery.

7.5.1.2 The results of surgical patients' diagnostic tests are recorded before surgery.

7.5.1.3 Surgical patients' preoperative diagnoses are recorded before surgery.

7.5.1.4 The anaesthetic assessment identifies any drug sensitivities.

7.5.1.5 An intra-operative report and a post-operative diagnosis are documented.

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

7.5.1.7 The patient's clinical status is monitored during the immediate post-surgery period.

7.6 Patient and family education

7.6.1 Each patient's educational needs are assessed and written in his or her record.

STANDARD INTENT:

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education. Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

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

Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record. Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example changing dressings, feeding and administering medication, they need to be educated.

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

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

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

CRITERIA:

7.6.1.1 Patients and families learn about participation in the care process.

7.6.1.2 Patients and families learn about any financial implications of care decisions.

7.6.1.3. Patients are educated about relevant high health risks, e.g. the safe use of medication and medical equipment or medication and food interactions.

7.6.1.4 The patient and family are taught in a language and format that they can understand.

7.6.1.5 Information given to the patient and family is noted in the patient's record.

7.6.1.6 There is evidence in the patient health record of informed consent for treatment.

7.7 Discharge process

7.7.1 There is an organised process for appropriately discharging patients.

STANDARD INTENT:

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

CRITERIA:

7.7.1.1 There is a documented process for appropriately discharging patients.

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

7.7.1.3 The medical practitioner gives patients (and their families when appropriate) understandable follow-up instructions in the discharge note at referral or discharge.

8. OPERATING THEATRE AND ANAESTHETIC SERVICES

OVERVIEW OF OPERATING THEATRE AND ANAESTHETIC SERVICES

Services in the operating theatre and anaesthetic services carry high risk. It is essential that there is collaboration between personnel in the theatre, the infection control personnel, health and safety personnel and those responsible for supplying and maintaining equipment.

Anaesthesia, sedation and surgical interventions are common and complex processes in a healthcare organisation. They require complete and comprehensive patient assessment, integrated care planning, continued patient monitoring and criteria-determined transfer for continuing care, rehabilitation and eventual discharge.

Anaesthesia and sedation are commonly viewed as a continuum from minimal sedation to full anaesthesia. As patient responses may move along that continuum, the use of anaesthesia and sedation is organised in an integrated manner. This Performance Indicator includes anaesthesia and moderate and deep sedation, during which the protective reflexes needed by the patient for ventilator functions are at risk.

The anaesthesia and surgery standards are applicable wherever anaesthesia and/or moderate or deep sedation are used and surgical and other invasive procedures requiring consent are performed. Such settings include healthcare facilities operating theatres, day surgery or day healthcare facility units, dental and other outpatient clinics, emergency services and others. While major surgery is generally not performed in clinics/health centres, minor procedures might be undertaken.

The organisation ensures that an adequate number of suitably qualified and experienced personnel are available at all times to provide a safe operating theatre and anaesthetic service.

STANDARDS

8.1 Management and staffing

8.1.1 The operating theatre and anaesthetic service is managed and staffed to provide a safe and effective service.

STANDARD INTENT:

Theatre management personnel work with organisational leaders to ensure adequate and suitable management processes and staffing of the theatre, anaesthetic service and recovery room. The qualifications of those persons who administer anaesthesia in the healthcare facility are documented in accordance with current professional society standards.

There may not be a formally constituted theatre users' committee but the function must be performed at some level. For example, in the private sector there are clinical forums where medical practitioners meet with management. These forums include representatives of the theatre nursing personnel. Privileges assigned to individuals may not be documented, but the organisation places restrictions on who may administer anaesthetics. In the private sector, privileging is implied by the fact that anaesthetists are permitted to provide services in an organisation only once their credentials have been checked.

CRITERIA:

8.1.1.1 A senior professional, who is suitably qualified and/or experienced is in charge of the theatre and recovery area.

8.1.1.2 Operating theatre rosters ensure that registered nurses with suitable qualifications and/or experience are present during all shifts for theatre duties, anaesthetic assistance and for recovery room duties.

8.1.1.3 Anaesthesia is administered only by qualified practitioners, who are privileged by the organisation to do so.

8.1.1.4 Anaesthesia is commenced and terminated only in the presence of a personnel member whose sole duty it is to assist the anaesthetist, until such time as the latter indicates that assistance is no longer required.

8.1.1.5 There is at least one suitably trained and/or experienced anaesthetic nurse per operating theatre.

8.1.1.6 Nurses, who are trained in recovery room care, are available until the patient has fully recovered.

8.1.1.7 The anaesthetist is responsible for supervising the recovery period and authorising the patient's discharge.

8.2 Facilities, equipment, supplies and medication

8.2.1 Facilities for safe surgical and anaesthetic care are provided and maintained.

STANDARD INTENT:

The design of the operating theatre provides space for the reception, anaesthesia, surgery, recovery and observation of patients. Access to the operating theatre suite is controlled. Anyone entering the area is required to change into theatre attire and wash their hands.

There are areas for the disposal and collection of used equipment and waste including contaminated waste and sharps. Safe and adequate storage space for pharmaceutical and surgical supplies is available. This includes separate lockable cupboards for medication requiring control in accordance with legislation or organisational policy and for flammable substances.

Theatre personnel are provided with office facilities or a day station, a restroom, washrooms, toilets, changing facilities and a separate space for their personal clothing and theatre clothing. There are facilities for scrubbing-up procedures in each theatre with hot and cold running water and elbowoperated taps. There is an anaesthetist's chair, an operating table with Trendelenburg position control, at least one lateral padded straight arm support and an infusion pole. Equipment for patients awaiting surgery includes blood pressure monitoring equipment, vacuum points with ancillary fittings and oxygen points with flowmeters and all ancillary fittings. Space and facilities are available for setting up surgical trays and for autoclaving instruments.

CRITERIA:

8.2.1.1 The design of the operating theatre complex provides space for the reception, anaesthesia, surgery, recovery and observation of patients.

8.2.1.2 Access to the theatre suite is controlled.

8.2.1.3 There is direct access to the operating theatres from the receiving, scrubbing-up and recovery areas.

8.2.1.4 The accommodation for patients awaiting surgery is suitably equipped.

8.2.1.5 There is safe and adequate storage space for pharmaceutical and surgical supplies.

8.2.1.6 There is access to sterilisation and disinfection facilities.

8.2.1.7 There is a system for controlling the environmental temperature and humidity that ensures safe limits for anaesthetised patients (temperature between 22 degrees Celsius and 25 degrees Celsius and relative humidity between 40% and 70%).

8.2.1.8 There is either an uninterrupted power supply (UPS) or a battery backup system for the theatre lamp, which is regularly tested, with such tests being fully documented.

8.2.1.9 There is a functional operating theatre table which is regularly tested, with such tests being fully documented.

8.2.1.10 The theatre has a refrigerator for medication, the temperature of which is measured and recorded daily.

8.2.2 The anaesthetic equipment, supplies and medication used comply with the recommendations of professional anaesthetic organisations or alternate authoritative sources.

CRITERIA:

8.2.2.1 The provision and use of anaesthetic mixture components and other peri-operative medication complies with the guidelines of a professional society or similar reputable professional body.

8.2.2.2 The provision and use of breathing circuits complies with the guidelines of a professional society or similar reputable professional body.

8.2.2.3 The provision and use of ancillary equipment complies with the guidelines of a professional society or similar reputable professional body.

8.2.2.4 The provision and use of monitoring equipment complies with the guidelines of a professional society or similar reputable professional body.

8.2.2.5 An anaesthesia trolley is available for the exclusive use of the anaesthetist in each theatre.

8.2.2.6 Expiry dates of medication are checked regularly, with documented records of such checks.

8.2.2.7 A tracheotomy tray is available.

8.2.2.8 Theatre personnel ensure that all equipment is included in the organisation's equipment replacement and maintenance programme.

8.2.3 Emergency and protective equipment and supplies are provided in the operating theatre.

CRITERIA:

8.2.3.1 Emergency resuscitation equipment and supplies are available.

8.2.3.2 Emergency resuscitation equipment and supplies have clearly defined instructions for use.

8.2.3.3 Emergency resuscitation equipment shows evidence of regular checking.

8.2.3.4 There is a mechanism for summoning assistance in the operating theatre.

8.2.3.5 There is appropriate shielding and protective clothing in the presence of biohazards (including lasers) or radiographic equipment.

8.2.3.6 Hazard or warning notices are displayed.

8.2.4 Recovery room facilities and equipment are available to provide safe and effective care.

STANDARD INTENT:

The number of beds/trolley spaces in the recovery room provides sufficient space for at least one patient from each operating theatre that it services and is sufficient for peak loads. The provision, use and maintenance of recovery room equipment comply with the guidelines for practice of the professional society.

CRITERIA:

8.2.4.1 The recovery area forms part of the operating theatre complex.

8.2.4.2 There is an adequate number of recovery beds for the patients from the operating theatre.

8.2.4.3 There is adequate lighting.

8.2.4.4 The provision, use and maintenance of recovery room equipment comply with the professional society's guidelines.

8.2.5 The sterilising and disinfecting unit is designed to allow for effective sterilising and disinfecting of equipment and supplies.

STANDARD INTENT:

Even in a small one-room unit, the separation of activity sites and the flow of work can be achieved by careful planning. There should be a dedicated area for cleaning equipment and instruments. There are many methods of sterilising equipment. Whatever methods are used, personnel need to ensure that the equipment used is effective. There must, therefore, be established systems for ensuring that sterility is obtained through the sterilisation processes. The number of autoclaves required will depend upon the size of the healthcare facility, the services provided, how much is processed on site and how much is acquired pre-packed and sterilised and whether the needs of both the operating theatre suite and other departments/services are catered for.

CRITERIA:

8.2.5.1 The design of the sterilising and disinfecting unit and the layout of equipment, ensures flow of work from the soiled to the clean side of the unit.

8.2.5.2 There is a washing and decontamination area with stainless steel sinks, running water and a sanitary sewage system.

8.2.5.3 There is a pre-packing area with storage facilities for clean materials.

8.2.5.4 There is a storage area for sterile packs with racks that allow for an adequate circulation of air.

8.2.5.5 Adequate light and ventilation are available.

8.2.5.6 There are one or more autoclaves or their equivalents that are capable of sterilising porous loads (gowns, drapes and dressings) as well as wrapped and unwrapped instruments.

8.2.5.7 Where ethylene oxide is used as a sterilising agent, the installation complies with relevant safety standards and legislation.

8.2.5.8 Autoclave sterility is tested daily and the test results are recorded.

8.2.5.9 The sterility of each pack is shown on indicator tapes that are suited to the processes used.

8.3 Policies and procedures

8.3.1 Policies and procedures are developed relating to the activities in the operating theatre and anaesthetic service.

STANDARD INTENT:

Policies and procedures are necessary to guide the administration of the operating theatre and anaesthetic services to ensure the smooth operation of those services and to ensure that personnel act swiftly and in a coordinated manner in an emergency. Those policies and procedures are made available to all theatre, recovery room and anaesthetic personnel and are known and implemented.

Biohazards that need to be monitored and notified include radiation, laser and electrical hazards.

Policies and procedures are available to ensure that informed consent is documented, the patient is correctly identified and the nature of and the site for surgery are correctly documented. Processes during the surgery, such as the use of instruments and counting procedures, are documented to ensure coordination and safety.

The implementation of policies will be assessed on site. For example, the assessor will require the person in charge to describe their performance step by step, while showing where and when/how to get the required equipment. At the same time, expiry dates, functioning of equipment and sterilisation processes will be inspected.

CRITERIA:

8.3.1.1 There are written policies and procedures to guide the activities of the theatre and the anaesthetic service.

8.3.1.2 Policies and procedures are developed relating to the preparation of patients for surgery.

8.3.1.3 Policies and procedures are developed relating to intra-operative recording.

8.3.1.4 Policies and procedures are developed relating to the anaesthetic service.

8.3.1.5 There are guidelines relating to the administration of major regional anaesthesia.

8.3.1.6 There are guidelines relating to the use of procedural sedation, where applicable.

8.3.1.7 Policies and procedures comply with current guidelines of the professional society.

8.4 Pre-operative and operative care

8.4.1 A pre-anaesthetic assessment is conducted and recorded.

STANDARD INTENT:

Because anaesthesia carries a high level of risk, its administration is carefully planned. The patient's pre-anaesthetic assessment is the basis for that plan and for the use of post-operative analgesia. The pre-anaesthetic assessment provides information needed to:

- Select the type of anaesthesia to be administered and plan anaesthetic care
- Identify any drug sensitivities
- Safely administer the appropriate anaesthetic
- Interpret the findings of patient monitoring

An anaesthesiologist or other qualified individual conducts the pre-anaesthetic assessment. Anaesthetic care is carefully planned and documented in the anaesthetic record. The plan considers information from other patient assessments and identifies the anaesthetic to be used, the method of administration, other medication and fluids, monitoring procedures and the anticipated post-anaesthetic care.

The anaesthetic planning process includes educating the patient and his or her family or decision maker regarding the risks, potential complications and options related to the planned anaesthesia and postoperative analgesia. This discussion occurs as part of the process of obtaining consent for anaesthesia. The anaesthesiologist or the qualified individual who will administer the anaesthetic provides this education.

CRITERIA:

8.4.1.1 An anaesthetic assessment of the patient is performed before the anaesthesia is administered.

8.4.1.2 The medical assessment of surgical patients is documented before the start of the anaesthesia.

8.4.2 Each patient's physiological status is monitored and recorded during anaesthesia and surgery.

STANDARD INTENT:

The anaesthetist monitors and records the physiological status of the patient during anaesthesia and enters the anaesthetic, medication and intravenous fluids used in the patient's anaesthetic record. The anaesthetist has access to the patient care notes and is familiarised with the findings of the medical examination. It is important that each health professional has access to the records of other care providers in accordance with organisational policy.

CRITERIA:

8.4.2.1 The patient's physiological status is continuously monitored and recorded during anaesthesia and surgery.

8.4.2.2 The anaesthesia, medication and intravenous fluids used is entered in the patient's anaesthetic record.

8.4.3 Each patient's post-anaesthetic status is monitored and the patient is discharged from the recovery area in accordance with accepted guidelines.

STANDARD INTENT:

Physiological monitoring provides reliable information about the patient's status during the administration of anaesthesia and the recovery period. Monitoring methods depend on the patient's preanaesthetic status, anaesthetic choice and the complexity of the surgical or other procedure performed during anaesthesia. In all cases the monitoring process is continuous, and the results are entered into the patient's record.

Monitoring during anaesthesia provides the basis for monitoring during the post-anaesthetic recovery period. The ongoing, systematic collection and analysis of data on the patient's status in recovery may support decisions about moving the patient to other settings and less intensive services. Only a suitably qualified and experienced registered nurse or designated member of the medical personnel may carry out monitoring in the recovery area. Recording of monitoring data provides the documentation to support discharge decisions.

The anaesthetist or other qualified individual decides whether the patient can be discharged from the recovery area to another level of care or from the organisation (as in the case of ambulatory anaesthesia). Standardised criteria developed by medical personnel are used to make discharge decisions. The decision to discharge the patient from the recovery area is entered into the patient's record. The time of arrival in, and discharge from, the recovery area is recorded. The signatures of those who handed over and those who received the patient are recorded.

CRITERIA:

8.4.3.1 During the post-anaesthetic recovery period, patients receive monitoring appropriate to their condition.

8.4.3.2 Monitoring findings are entered in the patient's record.

8.4.3.3 Established criteria are used to make decisions regarding the patient's discharge from the recovery room.

8.4.3.4 The decision to discharge the patient is recorded.

8.4.3.5 Recovery area arrival and discharge times are recorded.

8.4.3.6 The signatures of those handing over and those receiving the patient are recorded.

9. LABORATORY SERVICES

OVERVIEW OF LABORATORY SERVICES

Laboratory investigations and rapid reporting systems are essential for patient assessment and the implementation of treatment plans.

The facility may have its own laboratory service, or it may have an arrangement with an outside laboratory service. In either case, the service must meet applicable standards and Namibian laws and regulations.

The selection of an outside source to receive laboratory specimens for analysis is based on an acceptable record and compliance with Namibian laws and regulations.

Laboratory services must be available at those times required by the organisation, including emergency and after-hour services.

STANDARDS

9.1 Management of the service

9.1.1 Laboratory services are available to meet the needs of services and patients, in compliance with local and national laws, regulations and standards.

STANDARD INTENT:

The organisation has a system for providing the laboratory services, including clinical pathology services, required by its patient population, clinical services offered and healthcare providers' needs. The laboratory services are organised and provided in a manner that meets applicable local and national standards and Namibian laws and regulations.

Laboratory services, including those required for emergencies, may be provided within the organisation, by agreement with another organisation or both. Laboratory services are available after normal hours for emergencies.

Outside sources are convenient for the patients. The organisation selects outside sources based on the recommendations of the director or other individual responsible for laboratory services. Outside sources of laboratory services meet applicable Namibian laws and regulations and have acceptable records of accurate, timely services. Patients are informed when an outside source of laboratory services is owned by the referring physician.

Laboratory results are validated to ensure that they are those of the correct patient and physician. Validation includes the name of the validating officer.

Results are reported within a time frame based on patient needs, services offered and the needs of the clinical personnel. Emergency tests, after-hours and weekend testing needs are included. Appropriate specimen containers are available in the organisation with instructions for their correct use.

CRITERIA:

9.1.1.1 Adequate, convenient and regular laboratory services are available to meet the organisation's needs.

9.1.1.2 The laboratory services are organised and provided in a manner that meets applicable local and national standards, laws and regulations.

9.1.1.3 Emergency laboratory services are available, including after-hours services.

9.1.1.4 The organisation has established the expected report time for results.

9.1.1.5 Laboratory results are reported within a suitable time frame to meet patient needs.

9.1.1.6 Laboratory results are validated and include unique patient identity, date of testing/reporting, name and location of the requesting physician.

9.1.1.7 The validating officer is identified and recorded.

9.1.1.8 A list of referral laboratories is available for tests not performed on site.

9.1.1.9 There is a documented, implemented procedure for packaging specimens and transporting them to the referral laboratories.

9.1.1.10 A register is kept of the specimens sent to referral and outside laboratories and of the results.

9.1.2 A qualified individual is responsible for managing the laboratory service.

STANDARD INTENT:

The laboratory service is under the direction of an individual who is qualified by virtue of documented training, expertise and experience in accordance with applicable Namibian laws and regulations. This individual has professional responsibility for the laboratory facility and for the services provided. Speciality and sub-specialty laboratory services are under the direction of appropriately qualified individuals.

The responsibilities of the laboratory director include:

- Developing service-related policies and procedures and ensuring that they are implemented and reviewed regularly
- Managing relevant human resource functions, for example, position descriptions, personnel evaluation, personnel training
- Developing, coordinating and monitoring the required quality control and improvement systems

CRITERIA:

9.1.2.1 The laboratory is under the direction of a qualified individual.

9.1.2.2 The responsibilities of this person include maintaining quality control programmes.

9.1.2.3 The responsibilities of this person include administrative supervision.

9.1.2.4 The responsibilities of this person include monitoring and reviewing all the laboratory services.

9.1.3 Individuals with adequate training, skills, orientation and experience perform tests and interpret the results.

STANDARD INTENT:

The organisation identifies the laboratory personnel who may perform testing and who may direct or supervise testing. Supervisory and technical personnel have appropriate and adequate training, experience and skills and are oriented to their work. Technical personnel are given work assignments consistent with their training and experience. In addition, there are enough personnel to perform laboratory tests promptly and to provide the required laboratory services during all hours of operation and for emergencies.

The organisation can identify and contact experts in specialised diagnostic areas, such as parasitology or virology, when needed.

CRITERIA:

9.1.3.1 Qualified individuals are assigned to perform and supervise the provided laboratory services.

9.1.3.2 There are enough personnel to meet service needs.

9.1.3.3 On-going in-service training is provided to all personnel.

9.1.3.4 Records of the training provided are kept for all personnel.

9.2 Facilities and equipment

9.2.1 Laboratory buildings are adequate to provide a safe and effective laboratory service.

STANDARD INTENT:

Departmental managers need to work closely with organisational managers to ensure that facilities and equipment are adequate. Departmental managers keep organisational managers informed about inadequate facilities, the need for additional equipment requirements and the current state of facilities and equipment.

The general state of the laboratory will be checked. The walls, floor and ceiling should be in a good condition. As few items/instruments as possible should be placed on the floor.

CRITERIA:

9.2.1.1 The laboratory is a separate designated area within, or in close proximity to, the healthcare facility.

9.2.1.2 The size of the laboratory is appropriate to the services provided.

9.2.1.3 The ceiling and walls are clean and painted in a light colour.

9.2.1.4 The floor has a smooth and continuous surface.

9.2.1.5 The ceiling is not leaking and does not show signs of moisture.

9.2.2 Laboratory fixtures and fittings are adequate to provide a safe and effective laboratory service.

STANDARD INTENT:

The laboratory is constructed in such a way that it can provide the projected laboratory services. The laboratory must have sufficient and proper laboratory benches, washing and staining facilities, sufficient power and water requirements and preferably a controlled temperature.

Specific details that should be monitored are:

- Laboratory benches and equipment should be of a material that can support the laboratory instruments (strong) and should be of a material that cannot affect the surface of the table. Preferably the laboratory tables are constructed of concrete that is tiled. No wooden tables are allowed.
- At least one washing unit is available for standard cleaning and washing activities. When staining is performed two units are preferred.
- The number and quality of the available sockets should be sufficient for the projected activities.
- The water supply should be guaranteed to provide washing and staining activities.

CRITERIA:

9.2.2.1 There are sufficient laboratory benches for the projected activities.

9.2.2.2 Laboratory benches are strong enough for the projected activities (e.g. large instruments).

9.2.2.3 There is either an uninterrupted power supply (UPS), battery backup system and/or an automated voltage stabiliser (AVS) present for critical equipment, which are tested regularly and the results are fully documented.

9.2.2.4 Each laboratory compartment has adequate ventilation, with room temperature below 25 degrees Celsius and a temperature record is kept.

9.2.3 There is sufficient laboratory equipment that is adequate to provide a safe and effective laboratory service.

STANDARD INTENT:

It is essential that specific equipment is available in order to provide effective laboratory services. Laboratory management and personnel are responsible for the selection and availability of the critical instruments, their operation according to manufacturer's instructions and their appropriate maintenance.

The following must be considered:

- Processes for the selection and procurement of new instruments
- The availability of an equipment inventory management system
- The maintenance of the available equipment through inspection, testing and calibration
- Monitoring of and acting on equipment hazard notices, recalls, reportable incidents, problems and failures
- The availability of a system where activities are documented

Testing, maintenance and calibration frequencies are related to the laboratory's use of equipment and its documented history of service.

CRITERIA:

9.2.3.1 Sufficient equipment is available to provide the required laboratory services for the projected activities.

9.2.3.2 All equipment is in good working order, operated appropriately and functioning well.

9.2.3.3 Records are maintained to indicate that all equipment is regularly inspected, maintained and calibrated.

9.3 Reagents, chemicals and kits

9.3.1 The supplies of laboratory consumables, reagents, chemicals and kits are adequate to provide a safe and effective laboratory service.

STANDARD INTENT:

The organisation has identified those reagents and supplies needed regularly to guarantee the laboratory services provided to its patients. There is an effective process for ordering and ensuring that essential reagents and other supplies are available at all times. All reagents are stored and dispensed according to defined procedures. The periodic evaluation of all reagents, such as monitoring expiry dates, ensures accuracy and precise results. Written guidelines ensure the complete and accurate labelling of reagents and solutions.

CRITERIA:

9.3.1.1 The available supplies, consumables, reagents, chemicals and kits are sufficient for projected activities.

9.3.1.2 Specific laboratory reagents, chemicals and kits are used appropriately.

9.3.1.3 All reagents and chemicals are stored and dispensed according to guidelines.

9.3.1.4 All reagents and solutions are completely and accurately labelled.

9.3.1.5 All reagents are periodically evaluated for accuracy and results.

9.3.1.6 All reagents are stored in a lockable storage room or cupboard.

9.3.1.7 Where required, reagents are stored in the correct environment, e.g. controlled temperature, humidity, exposure to direct sunlight.

9.3.1.8 Dangerous reagents and chemicals are separately and securely stored.

9.3.1.9 All reagents are checked for expiry dates.

9.3.1.10 There is a documented stock management system that keeps track of current stock.

9.3.1.11 Re-order levels are defined.

9.4 Management of specimens (samples) and results

9.4.1 Procedures are followed for collecting, identifying, safely transporting and tracking specimens/samples and reporting the results.

STANDARD INTENT:

Procedures are developed and implemented for:

- Requesting laboratory tests (laboratory request form)
- Specimen collection and identification
- Specimen storage, preservation and transport
- Reviewing and authorising the laboratory results

There should be at least two log-books: only one patient log book and at least one log book for laboratory results. Dependent upon the size of the provider and the national requirements of the MOH, different log books for various disciplines are required or mandatory. Log books for laboratory results should not be directly linked to names. Patient log-books should contain name, date of visit, date of birth, gender, which services are requested, what material should be collected and the unique laboratory identification number. In the laboratory log-books only the unique laboratory number and results are registered. In other words, both log-books are required to match results to patient names.

Ideally, monthly overviews of the number of tests performed are generated.

Procedures should be available for administration, collection and reporting activities of specimens tested on site or sent to outside referral laboratories.

CRITERIA:

9.4.1.1 Policies and procedures (SOPs) for handling specimens are implemented.

9.4.1.2 Request forms are available and contain relevant information.

9.4.1.3 Specimen labels include unique patient identification and adequate supporting information.

9.4.1.4 Specimens are registered (handwritten or digital) legibly and in an organised manner.

9.4.1.5 Results are registered in a log-book.

9.4.1.6 Laboratory results are stored in lockable cupboard.

9.4.1.7 Policies and procedures (SOPs) regarding reporting and reviewing results are implemented.

9.4.2 Established norms and ranges are used to interpret and report clinical laboratory results.

STANDARD INTENT:

The laboratory establishes reference intervals or "normal" ranges for each test performed. The range is included in the clinical record either as part of the report or by including a current listing of such values, approved by the laboratory director. Ranges are furnished when an outside source performs the test. The reference ranges are appropriate to the organisation's patient population and are reviewed and updated when methods change.

CRITERIA:

9.4.2.1 The laboratory has established reference ranges for relevant tests.

9.4.2.2 The range is included in the clinical record at the time test results are reported.

9.5 Quality control

9.5.1 Quality control procedures are followed and documented.

STANDARD INTENT:

The quality of the laboratory services can be monitored using internal and external quality control guidelines. Designing and implementing internal and external quality control activities is essential for the final quality assurance of the laboratory results.

Sound quality control systems are essential to providing excellent pathology and clinical laboratory services. Quality control procedures could include:

- Validation of the test methods used for accuracy, precision and reportable range
- Daily surveillance of results by qualified laboratory personnel
- Rapid corrective action when a deficiency is identified
- Testing of reagents
- Documentation of results and corrective actions

Proficiency testing determines how well an individual laboratory's results compare with other laboratories that use the same methodologies. Such testing can identify performance problems not recognised by internal mechanisms. The laboratory must participate in an approved proficiency testing programme when one is available. Alternatively, when approved programmes are not available, the laboratory exchanges samples with a laboratory in another organisation for peer comparison testing purposes. The laboratory maintains a cumulative record of participation in a proficiency testing process. Proficiency testing, or an alternative, is carried out for all speciality laboratory programmes, when available.

CRITERIA:

9.5.1.1 There is a documented quality control system.

9.5.1.2 The laboratory participates in an external quality control programme.

9.5.1.3 There is a current register of quality control results and of the corrective and preventive actions taken.

9.6 Prevention and control of infection

9.6.1 The laboratory service implements infection prevention and control processes.

CRITERIA:

9.6.1.1 The service identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

9.6.1.2 Suitable processes are followed for cleaning and decontaminating laboratory surfaces and equipment.

9.6.1.3 Protective clothing is worn correctly.

9.6.1.4 Individuals who handle specimens are trained in the proper handling of dangerous specimens.

9.6.1.5 Organisational policy on post-exposure prophylaxis (PEP) is implemented.

9.6.1.6 Organisational policy on handling, storing and disposing of healthcare waste is implemented.

10. DIAGNOSTIC IMAGING SERVICES

OVERVIEW OF DIAGNOSTIC IMAGING SERVICES

The organisation is responsible for ensuring that the diagnostic imaging service meets the needs of its patient population, the clinical services offered and the healthcare providers.

These needs may be met by a service within the organisation or may be outsourced. In either case, the diagnostic imaging service must comply with all applicable local and national standards and Namibian laws and regulations.

The organisational leaders ensure that where a diagnostic imaging service is provided by the facility, there are radiation safety programmes in place and that individuals with adequate training, skills, orientation and experience are available to undertake diagnostic imaging procedures and interpret the results.

The diagnostic imaging service allows for immediate decision-making by practitioners through the provision of emergency services and the provision of emergency reports, as necessary.

STANDARDS

10.1 Management of the service

10.1.1 A diagnostic imaging service is provided by the organisation.

STANDARD INTENT:

The organisation has a system for providing the diagnostic imaging services required by its patient population, the clinical services offered and healthcare provider needs.

Diagnostic imaging services, including those required for emergencies, may be provided within the organisation, by agreement with another organisation or both. The diagnostic imaging service is available after normal hours for emergencies.

Outside sources are convenient for the patients and continuity of care is supported by reports that are received in a timely manner. These sources are selected by the organisation on the recommendation of the director or another individual responsible for radiology and diagnostic imaging services. Outside sources of diagnostic imaging meet applicable Namibian laws and regulations and have acceptable records of accurate and timely service. Patients are informed when the referring physician owns the outside source of diagnostic imaging.

CRITERIA:

10.1.1.1 An adequate, convenient and regular diagnostic imaging service is available.

10.1.1.2 An emergency diagnostic imaging service is available after normal hours.

10.1.1.3 The selection of an outside source is based on an acceptable record and compliance with applicable laws and regulations.

10.1.2 The diagnostic imaging service meets applicable local and national standards, laws and regulations.

STANDARD INTENT:

The organisation ensures that personnel are knowledgeable about the relevant legal requirements relating to diagnostic imaging. This is ensured by having available copies of the most recent radiation safety report and the local rules relating to the current Ionising Radiation regulations, together with other applicable documents that provide guidance relating to legality.

The organisation satisfies the statutory requirements of the Ionising Radiation regulations, according to the most recent radiation safety report.

There are organisational arrangements for obtaining advice on radiation protection and how to deal with a suspected case of overexposure.

CRITERIA:

10.1.2.1 Written policies and procedures address compliance with applicable standards, laws and regulations.

10.1.2.2 A copy of the local rules relating to the current Ionising Radiation regulations is available and the requirements are met.

10.1.2.3 A copy of the most recent radiation safety report is held.

10.1.2.4 The organisation satisfies the statutory requirements of the Ionising Radiation regulations.

10.1.2.5 A radiation protection supervisor is identified and available to assist a radiation protection adviser in complying with the Ionising Radiation regulations.

10.1.2.6 A patient register is held in the diagnostic imaging department.

10.1.3 A radiation safety programme is in place, followed and documented.

STANDARD INTENT:

The organisation has an active radiation safety programme that includes all components of the organisation's radiology and diagnostic imaging services. The radiation safety programme reflects the risks and hazards encountered. The programme addresses safety practices and prevention measures for radiology and diagnostic imaging personnel, other personnel and patients. The programme is coordinated with the organisation's safety management programme.

CRITERIA:

10.1.3.1 There is an established radiation safety programme that addresses potential safety risks and hazards encountered within or outside of the department.

10.1.3.2 The safety programme is part of the organisation's safety management programme.

10.1.3.3 Written policies and procedures address the handling and disposal of hazardous materials.

10.1.3.4 Identified radiation safety risks are addressed by specific processes or devices that reduce those risks, e.g. lead aprons, radiation badges, etc.

10.2 Facilities and equipment

10.2.1 Equipment and machines used to conduct diagnostic imaging studies are adequate and appropriate for the service provided.

STANDARD INTENT:

Diagnostic imaging personnel work to ensure that all equipment functions at acceptable levels and in a manner that is safe for the operators. A radiology and diagnostic imaging equipment management programme provides for:

- Selecting and acquiring equipment
- Identifying and inventorying equipment
- Assessing equipment use through inspection, testing, calibration and maintenance
- Monitoring and acting on equipment hazard notices, recalls, reportable incidents, problems and failures
- Documenting the management programme

Testing, maintenance and calibration frequency are related to the use of equipment and its documented history of service.

CRITERIA:

10.2.1.1 The organisation identifies the equipment required for the projected activities.

10.2.1.2 A diagnostic imaging equipment management programme is implemented.

10.2.1.3 There is an inventory of equipment.

10.2.1.4 There is documented evidence that equipment is tested and calibrated in accordance with organisational policy/SOP (standard operating procedure).

10.2.1.5 There is documented evidence that equipment is maintained in accordance with organisational policy/SOP.

10.2.2 X-ray film and other supplies are regularly available.

STANDARD INTENT:

The organisation has identified the quantities of film, reagents and supplies necessary to provide a radiology and diagnostic imaging service to its patients. There is an effective process for ordering or securing essential film, reagents and other supplies. All supplies are stored and dispensed in accordance with defined procedures. The periodic evaluation of reagents ensures accuracy and precise results. Written guidelines ensure the complete and accurate labelling of film, reagents and solutions.

CRITERIA:

10.2.2.1 Essential quantities of film, reagents and supplies are available.

10.2.2.2 All reagents and solutions are completely and accurately labelled.

10.2.2.3 Film and reagents are periodically evaluated for accuracy and results.

10.3 Diagnostic imaging procedures

10.3.1 Individuals with adequate training, skills and experience perform radiological procedures and interpret the results.

STANDARD INTENT:

The organisation identifies personnel who may perform procedures and those who may interpret radiological films and report the findings.

These personnel members have appropriate and adequate training, experience and skills and are oriented to their work. Radiographers are given assignments consistent with their training and experience. There are enough personnel to provide the necessary staffing during all hours of operation and for emergencies.

The organisation can identify and contact experts in specialised diagnostic areas such as radiation physics, radiation oncology or nuclear medicine when the need for such services arises. The organisation maintains a roster of such experts.

CRITERIA:

10.3.1.1 A qualified individual manages the diagnostic imaging service.

10.3.1.2 Those individuals who may perform X-ray procedures and those who may interpret and report the results are identified.

10.3.1.3 There is a mechanism that ensures that procedures are performed only by radiographers, radiologists or specially trained doctors and other persons who are authorised to do so by a radiation protection advisor.

10.3.1.4 X-rays are done only upon a signed request from a qualified medical practitioner.

10.3.1.5 X-rays are interpreted and reported on by appropriately trained and experienced personnel.

10.3.1.6 Experts in specialised diagnostic areas are contacted, when needed.

10.3.1.7 A roster of experts for specialised diagnostic areas is maintained.

10.3.1.8 Quality control procedures are implemented.

10.3.2 Reporting and recording policies and procedures within the diagnostic imaging service ensure safety and legality.

STANDARD INTENT:

X-ray request forms and the ensuing reports must identify the correct patient and the correct site of Xray. The organisation defines the time period for reporting diagnostic imaging test results. Results are reported within a time frame based on patients' needs, the services offered and the needs of the clinical personnel. Mechanisms are in place to ensure that X-ray results are reported on immediately in an emergency.

The X-ray films are the property of the patient and may be taken away by the patient. Where this is done, the patient must be asked to bring the films for future visits. Where the organisation stores films they are kept according to Namibian regulations.

CRITERIA:

10.3.2.1 Imaging request forms contain the patient's name, examination requested, relevant previous examinations and clinical information to explain the request.

10.3.2.2 Diagnostic imaging results are reported on by a qualified person within a time frame that meets clinical needs.

10.3.2.3 X-ray reports by a qualified person contain a clear conclusion (including recommendations for future treatment if appropriate).

10.3.2.4 A copy of the report is filed in the patient's record.

10.3.2.5 Films are available at each visit of the patient.

10.3.2.6 Policy defines the length and method of storage of X-ray films.

10.3.3 Where ultrasound services are provided, individuals with adequate training, skills and experience perform the procedures and interpret the results.

STANDARD INTENT:

The organisation identifies those personnel who may perform ultrasound procedures and those who may interpret and report the findings. These personnel members have appropriate and adequate training, experience and skills and are oriented to their work.

CRITERIA:

10.3.3.1 A qualified individual manages the ultrasound service.

10.3.3.2 Those individuals who may perform ultrasound procedures and those who may interpret and report the results are identified.

10.3.3.3 Ultrasound procedures are performed only by individuals with specific training.

10.3.3.4 Ultrasound images are interpreted and reported on by appropriately trained and experienced personnel.

10.3.3.5 Experts in specialised diagnostic areas are contacted, when needed.

10.3.3.6 A roster of experts for specialised diagnostic areas is maintained.

10.3.3.7 Quality control procedures are implemented.

11. MEDICATION MANAGEMENT

OVERVIEW OF MEDICATION MANAGEMENT

Depending on the size, structure and functions of the healthcare facility, there may be a pharmacy with qualified pharmacists to dispense medication or medical and nursing personnel may issue certain medication within the service. Whatever the system, the healthcare facility implements systems to ensure that all pharmaceutical practices are in accordance with current legislation. Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmaceutical and administrative personnel participate in a collaborative process to develop and monitor the policies and procedures.

Each healthcare facility has the responsibility of identifying the individuals with the requisite knowledge and experience who are permitted by Namibian laws, regulations or registration to prescribe or order medication. The healthcare facility also identifies any additional individuals who are permitted to prescribe or order medication in emergency situations. Policies and procedures define the documentation required for medication ordered or prescribed and for verbal medication orders.

Medication depends on suitable storage for their potency. In particular, vaccines which are exposed to high ambient temperatures and/or freezing will quickly lose their potency. The cold chain is the system of transporting and storing vaccines within the safe temperature range of 2 - 8°C. For vaccines to be effective, the cold chain must be maintained from the place of manufacture to the point of administration. Each time vaccines are exposed to the wrong temperature; their potency is reduced. To know if vaccines are potent at the time of administration, it is important that they be monitored for exposure to heat and cold as they pass through the cold chain. While domestic refrigerators are not designed to meet the requirements of vaccine storage, safe storage is possible if healthcare facilities follow simple guidelines. Guidelines may be obtained from the health authorities or from the manufacturers and distributors of vaccines. Foodstuff must not be stored in the medication refrigerator. Patient care units store medication in a clean and safe environment which complies with Namibian laws, regulations and professional practice standards.

The safe administration of medication requires a strict and comprehensive protocol. The patient, physician, nurse and other care providers work together to monitor patients on medication. The purposes of monitoring are to evaluate the response to medication, to adjust the dosage or type of medication, when necessary, and to evaluate the patient for adverse effects.

The healthcare facility identifies the adverse effects to be recorded and those that must be reported and it establishes the mechanism for reporting adverse events. The reporting process is part of the healthcare facility's performance improvement programme. The programme is focused on preventing medication errors through understanding the types of errors that occur. Improvements in medication processes and personnel training are used to prevent errors in the future. The pharmaceutical service participates in such personnel training, where appropriate.

STANDARDS

11.1 Management of the service

11.1.1 Medication use is organised throughout the facility to meet the needs of patients.

STANDARD INTENT:

As a crucial resource in patient care, the use of medication is managed effectively and efficiently throughout the organisation.

Applicable Namibian laws and regulations are incorporated into the organisational structure and the operations of the medication management system used in the organisation.

Where the organisation dispenses medication, it must be an approved, licensed site with the relevant personnel having approved licences issued for that site in accordance with Namibian legislation.

A registered pharmacist directly supervises the activities of the pharmacy or pharmaceutical service.

CRITERIA:

11.1.1.1 A designated individual, who is suitably qualified, has clearly defined responsibilities and accountability for all aspects of the pharmaceutical service.

11.1.1.2 Individuals who dispense medication act in accordance with legislation affecting pharmacy practice and current pharmaceutical, medical and nursing guidelines.

11.1.1.3 The scope of and limitations to the responsibilities and activities of personnel who manage medication are clearly defined.

11.1.1.4 The name of the responsible pharmacist is clearly displayed.

11.1.1.5 The pharmaceutical service is coordinated with other related services within the healthcare facility.

11.2 Facilities and equipment

11.2.1 Adequate facilities are available for the safe storage and dispensing of medication.

STANDARD INTENT:

Secure storage systems ensure that pharmaceuticals and related substances are held under conditions that conform to statutory requirements and the manufacturer's requirements.

There are arrangements for ensuring the security of medication including alarm systems, door access controls and safes/vaults for storing controlled medication. Medication stored and dispensed from areas outside the pharmacy, for example patient care units, comply with the same safety measures.

There is a registry, log or other mechanism to monitor and account for controlled substances. Deep freeze, refrigeration, cold room and cool area facilities are provided for safe storage of certain medication. There is a mechanism for ensuring that the correct temperature is maintained throughout the life of the medication. Deep freezers and refrigerators are defrosted when necessary. Doors, hinges and seals are all functional.

CRITERIA:

11.2.1.1 The design and layout of the pharmacy must permit a logical, safe flow of work, adequate storage space, effective communication and supervision, and ensure effective cleaning and maintenance.

11.2.1.2 Secure facilities for the storage of medication includes, but is not limited to, lockable storage facilities, ceiling cages, burglar guards and alarm systems with keypads.

11.2.1.3 The storage area is easily accessible from the dispensing room.

11.2.1.4 Medication storage areas are protected from heat and light and are effectively ventilated.

11.2.1.5 A dedicated refrigerator is available for medication requiring storage at low temperatures.

11.2.1.6 A monitoring log is kept of the temperature within the refrigerator and/or cold-chain monitors and any remedial action taken is recorded.

11.2.1.7 The work bench for preparing medication for dispensing should be clean, tidy and well organised.

11.2.1.8 The area where medication is dispensed to the patients is easily accessible, adequately furnished and allows for reasonable privacy when advice is given.

11.3 Policies and procedures

11.3.1 There is a collaborative effort to develop and monitor policies and procedures for the pharmaceutical service.

STANDARD INTENT:

Safe pharmaceutical practices are guided by organisational policies and procedures. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor the policies and procedures.

The clinical and managerial leaders use a collaborative process to develop policies and procedures and to ensure the training of all personnel on their implementation.

It is particularly important that the policies or procedures indicate:

- How planning will occur
- The documentation required for the care team to work effectively
- Special consent considerations
- Monitoring requirements
- Special qualifications or skills of personnel involved in the care process
- The availability and use of resuscitation equipment

Clinical guidelines are frequently helpful and may be incorporated in the process. Monitoring provides the information required to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

Policies and procedures should focus on at least the following high-risk procedures:

a) Safe prescribing, ordering, transcribing and administering medication in the organisation
b) Documentation requirements
c) The use of verbal medication orders
d) The availability and use of medication samples
e) Documentation and management of any medication brought into the organisation for or by the patient
f) Self-administration of medication by the patient
g) Dispensing of medication at the time of the patient's discharge
h) Preparing, handling, storing and distributing parenteral and enteral nutrition products
i) Storing, handling, distributing and dispensing hazardous medication
j) Storing, handling, distributing and dispensing of investigational medication
k) Managing medication used in clinical trials
l) The security of personnel, equipment and stock

CRITERIA:

11.3.1.1 Policies and procedures are developed and implemented for identified processes, which include at least those from a) to l) in the standard intent above.

11.3.1.2 Policies and procedures are implemented to ensure that medication is procured according to Namibian guidelines regarding specific agents and approved suppliers.

11.3.1.3 Policies and procedures are implemented to ensure that medication is transported to the facility in accordance with manufacturers' guidelines, with specific emphasis on maintaining cold chain requirements.

11.3.1.4 Policies and procedures are implemented to ensure that medication is dispensed on the written instructions/prescription of a designated healthcare worker who is qualified and/or experienced in their use.

11.4 Access to appropriate medication

11.4.1 An appropriate selection of medication for prescribing or ordering is stocked or readily available.

STANDARD INTENT:

Every organisation must decide which medication to make available for prescribing and ordering by the care providers. This decision is based on the organisation's mission, patient needs and the type of services provided. The organisation develops a list of all the medication it stocks or that are readily available from outside sources. In some cases, Namibian laws or regulations may determine the medication on the list and/or their source. Medication selection is a collaborative process which considers patient needs and safety as well as economics. The organisation has a method, such as a committee, for monitoring and maintaining this medication list and for monitoring the use of medication within the organisation.

Managing medication use in an organisation requires an understanding of the sources and uses of medication not prescribed or ordered within the organisation. On occasion, medication not readily available to the organisation are needed. There are also occasions where medication is needed at times when pharmacies are closed. Each organisation needs to plan for these situations and to educate personnel regarding the procedures to follow should they occur. When patient emergencies occur, quick access to appropriate emergency medication is critical. Each organisation plans the location of emergency medication and the medication to be supplied in these locations. To ensure access to emergency medication when needed, the organisation establishes a procedure or process to prevent theft or loss of the medication and to ensure that medication is replaced when used, damaged or expired. Each organisation also needs to determine its role in providing medication to patients at discharge.

Those who prescribe or order medication know what medication, if any, are available and how to obtain them.

CRITERIA:

11.4.1.1 There is a list of medication stocked in the organisation or readily available from outside sources.

11.4.1.2 Priority essential drugs are in stock.

11.4.1.3 There is a process for obtaining required medication that is not stocked or normally available to the organisation.

11.4.1.4 There is a process for healthcare workers to obtain medication within the facility when the pharmacy is closed.

11.4.1.5 There is a list of medication available in the emergency cupboard, where relevant.

11.4.1.6 There is a system for recalling medication, when required.

11.5 Control and storage of medication

11.5.1 Medication is stored in a secure and clean environment.

STANDARD INTENT:

The pharmacy or pharmaceutical service, stores and dispenses medication in a clean and secure environment which complies with Namibian laws, regulations and professional practice standards. Medication is clearly labelled, which includes the following:

- Generic name and strength of medication
- Dose, frequency and duration of course
- Date of dispensing and expiry date
- Name of patient
- Name/address of supplier
- Child safety warning
- Batch number

Medication stored and dispensed from areas outside the pharmacy, for example patient care units, comply with the same safety measures.

There is a registry, log or other mechanism for monitoring and accounting for controlled substances.

CRITERIA:

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

11.5.1.2 There is a system for ensuring that maximum and minimum stock levels are maintained.

11.5.1.3 Medication is legibly marked and securely labelled.

11.5.1.4 Medication controlled by law or organisational policy is stored in a cabinet of substantial construction for which only authorised personnel have the keys.

11.5.1.5 Medication controlled by law or organisational policy is accurately accounted for in a specific register.

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

11.5.1.7 All pharmaceuticals, vaccines or medical consumables are regularly checked for expiry dates and checks are recorded.

11.5.1.8 A manual (stock cards) or automated inventory management system is in place and functioning appropriately, e.g. to monitor and control stock losses.

11.5.1.9 Separate designated storage areas are provided for materials under quarantine, e.g. expired stock, compounded products.

11.6 Prescribing of medication

11.6.1 There is a process to ensure the safe and legal prescribing of medication.

CRITERIA:

11.6.1.1 Only those permitted by the healthcare facility and by relevant laws and regulations prescribe medication.

11.6.1.2 Prescriptions conform to legal requirements.

11.6.1.3 Prescription pads and order books are accessible to authorised persons only.

11.6.1.4 There is a process for placing limits, when appropriate, on the prescribing or ordering practices of individuals.

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

11.7 Dispensing Medication

11.7.1 The organisation adheres to laws, regulations and professional standards of practice when dispensing medication.

STANDARD INTENT:

A registered pharmacist reviews each prescription or order for medication. When questions arise, the individual who prescribed or ordered the medication is contacted.

The dispenser signs the prescription. When pharmacist assistants or interns dispense, they are supervised and their signatures, as dispensers, are countersigned by a registered pharmacist. The organisation dispenses medication in the most ready-to-administer form possible to minimise opportunities for error during distribution and administration. The central pharmacy and other medication distribution points throughout the organisation use the same system. The system supports accurate dispensing of medication in a timely manner.

CRITERIA:

11.7.1.1 Pharmacy personnel act in accordance with legislation and current pharmaceutical, medical and nursing guidelines.

11.7.1.2 Medication is prepared and dispensed in a safe and clean environment.

11.7.1.3 There is a uniform medication dispensing and distribution system in the organisation.

11.7.1.4 The system supports accurate and timely dispensing.

11.7.1.5 Medication is securely and legibly labelled with relevant information as required by organisational policy.

11.7.1.6 A register is maintained of all medication dispensed.

11.7.1.7 The person prescribing and dispensing the medication has access to patient information that would contraindicate particular medication.

11.7.1.8 The person dispensing the medication informs the patient of available generic equivalents.

11.7.1.9 There is a mechanism for facilitating communication between the doctor and the pharmacy regarding drug reactions.

11.7.1.10 Prescriptions are securely stored in accordance with legislation or organisational policy.

11.8 Administration of medication

11.8.1 Medication is administered in a manner that ensures safety and effectiveness.

CRITERIA:

11.8.1.1 Only those permitted by the healthcare facility and by relevant laws and regulations administer medication.

11.8.1.2 Medication is verified against the prescription or order, including the dosage and route of administration.

11.8.1.3 Patients are identified before medication is administered.

11.8.1.4 Medication is administered as prescribed.

11.8.1.5 The therapeutic results of administered medication are monitored.

11.8.1.6 Adverse medication reactions are observed, monitored and reported.

11.8.1.7 Medication errors are reported in accordance with policy.

12. OCCUPATIONAL HEALTH SERVICE

OVERVIEW OF OCCUPATIONAL HEALTH SERVICE:

The functions relating to occupational health services are diverse and for the purposes of this service element will be categorised according to the requirements necessary to provide a comprehensive service.

Occupational health services need to take into consideration the health risks specific to the work environment of employees. With regard to work related risks, the occupational health personnel should work closely with organisational and healthcare facility leaders to ensure that risks are identified, assessed, controlled and monitored and that the control measures implemented are monitored for effectiveness.

Health education specific to the risks of the work environment is offered routinely to ensure that employees have sufficient knowledge to mitigate the risk of their work environment to themselves and others. This aspect of the service is especially important as occupational health workers are ideally placed, trained and tasked to offer such advice.

The occupational health service encourages an organisational culture that strives for continual improvement in accident rates and aims to eliminate accidents and risk to ill-health.

STANDARDS

12.1 Organisation and coordination

12.1.1 The service is organised to provide a safe and effective service and is coordinated with other relevant services.

CRITERIA:

12.1.1.1 The lines of communication between the health facility, referral facilities and community services are clearly defined.

12.1.1.2 Relations are established, and contact maintained with other relevant services and agencies, including both governmental and non-governmental agencies.

12.1.1.3 An on-call roster is available for after hour, weekend and public holiday emergency coverage (e.g. for infectious diseases).

12.1.1.4 Arrangements are in place to assure that adequate referral services are available.

12.1.1.5 Laboratory services are available to meet the needs of patients.

12.1.1.6 A register is kept of all laboratory specimens sent and results received.

12.1.1.7 Radiology services are available to meet the needs of patients.

12.2 Facilities and equipment

12.2.1 Required furniture and equipment are available and functioning appropriately.

STANDARD INTENT:

In order to provide safe patient care, each unit requires adequate resources. An assessment is made as to whether the facility has the required furniture and equipment. Facilities will be required to complete an inventory of their furniture and equipment based on the standard lists and to report the percentage of total items they have in stock relative to the total recommended.

The physical facilities required include adequate office accommodation for occupational health personnel.

Management must ensure that resources are adequate to meet statutory requirements and the needs of clients. Occupational health managers keep the healthcare facility managers informed of facilities which are inadequate, additional equipment requirements, and the current state of facilities and equipment.

CRITERIA:

12.2.1.1 Occupational health offices are clearly sign-posted.

12.2.1.2 There is a mechanism to prevent unauthorised individuals from entering the offices.

12.2.1.3 There is a reception area for the public.

12.2.1.4 There is adequate office space for administrative activities.

12.2.1.5 There is privacy for interviewing members of the public and clients.

12.2.1.6 Lockable facility for storing personal clothing and property are provided.

12.2.1.7 Ablution facilities are provided.

12.2.1.8 Transport is available for occupational health officers to perform their functions.

12.2.1.9 Facilities and equipment are maintained to provide clean and safe working conditions, which comply with relevant legislation.

12.2.1.10 Records of equipment maintenance are available.

12.3 Management of the Occupational Health Service

12.3.1 The occupational health service is managed, to provide personnel and resources required for an effective service.

CRITERIA:

12.3.1.1 A designated person is responsible and accountable for the management of the occupational health service.

12.3.1.2 There are an adequate number of suitably qualified and trained personnel to provide for the needs of the occupational health service.

12.3.1.3 Occupational health personnel have the necessary and appropriate training, credentials and skills to carry out their responsibilities.

12.3.1.4 Occupational health personnel participate in continuing medical education in occupational health.

12.3.1.5 Occupational health personnel have appropriate access to a physician with expertise and credentials in occupational health care.

12.3.2 The mission statement and overall policy of the occupational health service reflect current international best practice.

STANDARD INTENT:

The Occupational health service has a mission statement that reflects the needs of employees (its clients) and services are designed and planned to respond to those needs. The service has an overall policy, authorised by management that contains the mission statement and clearly states the objectives of the service. The policy includes:

a) A commitment to comply with relevant OHS legislation, local government bylaws and industry requirements.
b) A commitment to promote a culture of health and safety within the workplace
c) A commitment to close collaboration with the health and safety committees in all aspects relating to health and safety in the workplace

The policy is appropriate to the nature and scale of the risks specific to the workplace. The policy is communicated to all employees.

CRITERIA:

12.3.2.1 The occupational health service has an overall policy that contains as a minimum a mission statement and points a) – c) set out above.

12.3.2.2 The policy is authorised by senior management.

12.3.2.3 The policy is clearly displayed within the department, communicated to all employees and available to all interested parties.

12.3.2.4 The policy is reviewed at appropriate intervals as determined by the organisation, but at least 3 yearly.

12.3.2.5 The services to be offered are consistent with the mission of the service.

12.3.2.6 The services to be provided are described in the strategic plans of the service.

12.3.3 Where students are trained as part of undergraduate or postgraduate programmes, the occupational health service ensures formal training.

CRITERIA:

12.3.3.1 There is a designated member of the staff of the occupational health service who coordinates student training.

12.3.3.2 The training programme is structured in accordance with the guidelines of the appropriate registration body and training facilities.

12.3.3.3 Training periods are recorded and evaluated.

12.4 Provision of Occupational Health services

12.4.1 The functions of the occupational health practitioners are provided in accordance with ethical and professional practices and legal requirements.

STANDARD INTENT:

There are documented policies which are implemented to ensure that relevant current legislation is readily available and accessible (this can be either in electronic format or hard copies). The policy includes a requirement for regular review of legislation and replacement of outdated legislation. The policy also outlines procedures for the clear identification, removal and storage of outdated legislation to guard against unintended use.

CRITERIA:

12.4.1.1 Occupational health services are provided in accordance with relevant standards promulgated by local government and national guidelines, laws and regulations.

12.4.1.2 Copies of relevant laws and regulations are available and readily accessible.

12.4.1.3 Copies of relevant local government bylaws are available and readily accessible.

12.4.1.4 Legislation is reviewed regularly at a frequency determined by the organisation but at least every three years and the reference records updated accordingly.

12.4.1.5 If kept for research or knowledge purposes, out-dated legislation is clearly marked as such, removed from the current reference records and stored in such a way as to guard against unintended use.

12.4.2 The occupational health service provides appropriate medical care to the employees of the organisation.

STANDARD INTENT:

The occupational health service provides appropriate medical care to employees of the organisation which takes account of the employee's work environment where appropriate. Due consideration is given to the mental as well as the physical health of the workforce.

CRITERIA:

12.4.2.1 Occupational health service personnel are informed of the potential workplace hazards for each employee.

12.4.2.2 Occupational health service personnel have ready access to appropriate reference materials regarding occupational health care.

12.4.2.3 Where routine medical care is offered to employees by the occupational health service, medical complaints by employees are differentiated in terms of workplace related complaints and other medical conditions.

12.4.2.4 Medical complaints by employees are managed with consideration given to the relationship to the workplace environment and work practices.

12.4.2.5 Medical complaints by employees are managed with consideration given to the employee's fitness to continue present work practices.

12.4.2.6 Medical complaints by employees are managed with consideration given to any disability that may have been sustained.

12.4.2.7 The management of an acute injury includes measures to minimise disability and to return the employee to an optimal functional state as soon as possible.

12.4.2.8 Employees are screened for mental health issues that may arise from working conditions, illness or disability and managed appropriately.

12.4.2.9 Records reflect both screening for and management of mental health issues.

12.4.3 Details of the organisation's absenteeism and sickness rates are recorded and analysed to allow for informed decision-making by the management of the organisation.

CRITERIA:

12.4.3.1 Employees who are absent from work are evaluated to ensure that they have regained sufficient health to be returned to their particular work place.

12.4.3.2 Such evaluation includes, but is not limited to, the extent and duration of the condition that caused the absence from work.

12.4.3.3 Such evaluation includes, but is not limited to, the extent and duration of potential hazards that may affect the employee's health.

12.4.3.4 Analysis of staff absenteeism and sickness provides data for planning for risk management, for example analysis of back injuries causing staff sickness and absenteeism.

12.4.4 The organisation has an appropriate medical surveillance programme, which meets the needs of the population served.

STANDARD INTENT:

The organisation identifies risks within the organisation that require health surveillance as part of the risk management programme. An appropriate health surveillance programme is designed and implemented by adequately trained staff. The programme includes an effective recall system. Employees state of health is determined when joining the organisation and again upon leaving as part of the health surveillance service. Employees are aware of their right to have access to their records.

CRITERIA:

12.4.4.1 The health surveillance programme is appropriate for the health risks to which employees are exposed.

12.4.4.2 The data collection process is designed to provide information that can be used in determining measures to eliminate, control and minimise the health risks to which employees are exposed.

12.4.4.3 There is an effective recall system to ensure that employees are seen at appropriate intervals.

12.4.4.4 Staff responsible for the development and implementation of the health surveillance programme are appropriately trained and updated.

12.4.4.5 Records of each employee under surveillance are appropriately stored and managed in accordance with the standards set out in SE 4 and appropriate legislation.

12.4.4.6 Records are available to the employee upon request.

12.4.4.7 Employees are aware of their right to access their records relating to the health surveillance programme.

12.4.4.8 Pre-employment examinations that consider the health of the individual and the requirements of the prospective workplace are provided.

12.4.4.9 Pre-termination examinations are provided when employees leave the employ of the facility to provide accurate information on their state of health on departure.

12.4.4.10 Lifestyle habits (weight, diet, exercise, alcohol and/or tobacco use, etc.) are assessed, when potential exposure to hazardous agents may be affected by those habits.

12.5 Health promotion

12.5.1 The occupational health service builds capacity in the work place through the provision of information, education and counselling services.

STANDARD INTENT:

Occupational health practitioners play a significant role in empowering the work force to take responsibility for their own healthy environment in addition to the responsibility of healthcare providers to provide relevant health promotion and educational messages.

Posters are a useful aid in the dissemination of relevant health information. Posters are displayed in all appropriate areas for the purpose of providing health education to the employees specific to their health, work environment and patient rights. The posters are appropriate for the population served in terms of language and comprehension.

The posters provide information on:

a) Health and safety risks relevant to the organisation
b) Mental health issues relevant to the work environment
c) Encouraging compliance with measures to protect their own health and safety and that of others, for example, wearing of protective clothing and following appropriate procedures
d) Correct procedures to follow if they feel that a new risk has emerged which threatens the health and safety of the workforce or environment
e) Right of access to health records and the results of any investigations
f) Right to refuse to work in areas that they feel to be unsafe
g) Health issues such as TB, HIV and substance abuse

Relevant health education is provided in all consultations and documented in the patient records.

CRITERIA:

12.5.1.1 The occupational health service works with personnel of other health services, nongovernmental organisations and local governmental structures to provide health education and build capacity within the work force.

12.5.1.2 Posters are displayed in relevant areas within the facility covering at least points a) to g) in the intent statement above.

12.5.1.3 HIV counselling and screening services are offered with due regard for confidentiality.

12.5.1.4 Information provided is appropriate for the language/s and comprehension of the population served.

12.6 Communicable diseases

12.6.1 The occupational health service undertakes monitoring and prevention measures for notifiable medical conditions and communicable diseases where relevant.

CRITERIA:

12.6.1.1 The occupational health service identifies, investigates and monitors the outbreak of communicable disease when indicated.

12.6.1.2 The occupational health service institutes the necessary corrective and preventive occupational health measures.

12.6.1.3 The occupational health service participates in the development of necessary reaction teams in relation to local government health measures.

12.6.1.4 The occupational health service promotes health and hygiene aimed at the prevention of occupational conditions that lead to communicable diseases.

12.6.1.5 The occupational health service gathers, analyses and distributes epidemiological data and information.

12.6.1.6 There is an appropriate system in place for the prompt reporting of notifiable medical conditions.

12.6.1.7 There is a system in place to ensure the referral and uptake of confirmed cases of relevant communicable diseases into appropriate treatment programmes.

12.7 Information management

12.7.1 There is a system to ensure that reports and records are efficiently managed with due regard for confidentiality.

CRITERIA:

12.7.1.1 There is documented evidence that the occupational health practitioners write reports on occupational health related issues.

12.7.1.2 There is documented evidence that the occupational health practitioners write letters and serve notices to remedy occupational health problems.

12.7.1.3 There is documented evidence that the occupational health practitioners record and file health related statistics and evaluate trends.

12.7.1.4 There is documented evidence that the occupational health practitio7ners complete questionnaires from an occupational health perspective.

12.7.1.5 There is documented evidence that the occupational health practitioners provide reports and comments on inspections, complaints and investigations.

12.7.1.6 There is documented evidence that the occupational health practitioners compile occupational health report forms.

12.7.1.7 There is documented evidence that the occupational health practitioners utilise standard or prescribed occupational health report forms or recording systems in respect of inspections, investigations and work of a recurring nature e.g. notifiable medical conditions.

12.7.1.8 Personal information about an employee that is unrelated to the ability to perform the specified job safely is handled in a confidential manner.

12.7.1.9 Signed consent is obtained from patients prior to the release of any patient related information.

12.7.2 The organisation establishes, implements and maintains procedures for controlling relevant documents and data.

CRITERIA:

12.7.2.1 Current versions of relevant documents and data are available at all locations where operations essential to the effective functions of the occupational health service are performed.

12.7.2.2 Documents and data are periodically reviewed, revised as necessary and approved by an authorised person.

12.7.2.3 Obsolete documents and data are promptly marked as such and removed from all points of issue and points of use or otherwise assured against unintended use.

12.7.2.4 Archived documents and data retained for legal or knowledge preservation purposes or both are suitably identified.

12.8 Quality management and improvement

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

STANDARD INTENT:

This refers to the implementation of organisational quality improvement processes.
It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. It is the responsibility of managers within each department or service to ensure that standards are set for the particular department. This requires coordination with the organisation's central management coordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

The following will be evaluated:

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

CRITERIA:

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

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

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

12.8.1.4 A documentation audit system is in place.

12.9 Prevention and control of infection

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

STANDARD INTENT:

The health of occupational health personnel, like all healthcare workers, should be protected from work related risks. Healthcare workers are at higher risk of contracting infectious diseases and as such appropriate measures are in place to minimise these risks.

Criteria:

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

12.9.1.2 Individuals who collect specimens are trained in the proper collection and handling of microbiological specimens.

12.9.1.3 Organisational policies and procedures for the prevention and control of infection are readily available in the department.

12.9.1.4 Policies and procedures address the correct management of sharps within the department.

12.9.1.5 Post exposure prophylaxis kits are readily available for staff who sustain needlestick injuries.

12.9.1.6 Information regarding needlestick injuries is recorded and action taken as appropriate.

12.9.1.7 Personnel are routinely offered BCG and vaccination for Hepatitis B.

12.9.1.8 Seroconversion is measured and recorded in personnel folders.

12.9.1.9 Booster vaccinations are offered as appropriate.

12.10 Risk management

12.10.1 Risks to the health and safety of staff, patients or visitors are assessed and control measures introduced in order to minimise or eliminate risk and promote safety.

STANDARD INTENT:

The goal is to prevent accidents and injuries, maintain safe and secure conditions for patients, personnel and visitors, and reduce and control hazards and risks.
This can be done by comprehensively inspecting the facility, with particular reference to hazardous processes, equipment, substances, procedures and environments. This periodic inspection is documented and helps the organisation plan and implement improvements and budget for longer term facility upgrading or replacement. Then, with an understanding of the risks present in the organisation's physical facility, the organisation can develop a proactive plan to reduce those risks for patients, personnel and visitors. This plan includes safety, security and hazardous materials.

CRITERIA:

12.10.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of the organisational programme.

12.10.1.2 The occupational health personnel are included in assessment of risks to the health of the staff attached to any work.

12.10.1.3 The occupational health personnel have access to and utilise, as appropriate, consultative services associated with evaluating workplace hazards such as industrial hygiene, workplace toxicology, ergonomics and epidemiology.

12.10.1.4 There are monitoring mechanisms to ensure that staff members adhere to safe systems of work, including the use of protective clothing.

12.10.1.5 Vulnerable groups of workers are identified.

12.10.1.6 Where there is risk of injury, it has been determined whether it is possible to avoid manual handling or to provide mechanical aids in place of the latter.

12.10.1.7 There is a mechanism to ensure that the staff are aware of risks and their consequences.

12.10.1.8 Documented information on the safe handling and storage of hazardous substances is available and provided to the management of the organisation.

12.10.1.9 First aid is available to the staff.

12.10.1.10 A system for the monitoring of negative incidents/near misses/adverse (sentinel) events is available, which includes the documentation of interventions and responses to recorded incidents.

12.10.1.11 Security measures are in place and implemented to safeguard and protect patients, staff and visitors.

12.10.1.12 Fire safety measures are implemented.

12.10.1.13 Organisation policy on handling, storage and disposal of healthcare waste is implemented.

ANCILLARY SERVICES

13. FACILITY MANAGEMENT SERVICES

OVERVIEW OF FACILITY MANAGEMENT SERVICES

The Facility Management department concerns itself with the management and maintenance of the facility's plant, machinery, buildings and equipment.

Namibian laws, regulations and inspections by national government and local authorities determine in large part how a facility is designed, used and maintained. All organisations, regardless of their size and resources, must comply with these requirements as part of their responsibilities to their patients, families, personnel and visitors. Organisations begin by complying with laws and regulations. Over time, they become more knowledgeable about the details of the physical facility they occupy and begin to proactively gather data and carry out strategies to reduce risks and enhance the patient care environment.

Buildings, grounds, plant and machinery are provided and maintained and do not pose hazards to the occupants. Utility systems (electrical, water, oxygen, ventilation, vacuum and other utility systems) are maintained to minimise the risks of operating failures.

Ensuring that buildings, grounds, plant and machinery are provided and maintained requires that personnel be knowledgeable and competent.

STANDARDS

13.1 Facilities and equipment

13.1.1 Functional facilities are available to provide safety and comfort for patients, visitors and personnel.

STANDARD INTENT:

Namibian laws, regulations and inspections by national government and local authorities determine in large part how a facility is designed, used and maintained. All organisations, regardless of size and resources, must comply with these requirements as part of their responsibilities to their patients, families, personnel and visitors.

Buildings, grounds, plant and machinery are provided and maintained and do not pose hazards to the occupants. The construction of the building in terms of walls, ceilings, floors, doors and windows must be sound. The general appearance will be examined for neatness, condition of paintwork, signs of leakage, mould spots, etc.

Utility systems (electrical, water, oxygen, ventilation, mosquito screening and other utility systems) are maintained to minimise the risks of operating failures. Ensuring that buildings, grounds, plant and machinery are provided and maintained requires that personnel be knowledgeable and competent.

CRITERIA:

13.1.1.1 Laws, regulations and other requirements applicable to the organisation's facilities are available in writing to personnel.

13.1.1.2 The building is appropriate as a healthcare facility in terms of size and lay-out.

13.1.1.3 Mosquito net screening is available at the outside windows and doors throughout the facility, where applicable.

13.1.1.4 All rooms are adequately ventilated.

13.1.1.5 Where required, air-conditioning is installed in laboratories, pharmacies, operating theatres and sterilising departments and is tested and maintained.

13.1.1.6 Temperature and ventilation control mechanisms are installed and maintained in the pharmacy, laboratory, kitchen, laundry and other relevant areas.

13.1.1.7 Toilet/washroom facilities are clean and in working order.

13.1.1.8 There is a separate area for personnel, with adequate secure storage facilities for outdoor clothing, handbags and personal possessions.

13.1.1.9 Sufficient office/administrative space is available for personnel.

13.2 Buildings, plant, installations and machinery

13.2.1 The maintenance service is managed to ensure the provision of a safe and effective service.

STANDARD INTENT:

A suitably qualified individual with proven competence is appointed to manage the service. The accountabilities and responsibilities of this individual are clearly defined.

Management ensures that enough competent personnel are available to manage routine and emergency functions and meet the needs of a safe and effective health service. Personnel may be in the employ of the organisation or be outsourced. Where there are contracted personnel, there must be clear contracts outlining their responsibilities. The roles of personnel need to be clearly defined and management needs to ensure that they maintain their competence.

CRITERIA:

13.2.1.1 A designated, competent individual is responsible for supervising the maintenance of buildings, plant and installations.

13.2.1.2 Where these services are outsourced, the organisation's personnel have access to a list of these private contractors with their contact numbers.

13.2.1.3 Written agreements ensure 24-hour technical back-up services.

13.2.1.4 Written policies and procedures guide the organisation's personnel in the implementation of all service-related requirements.

13.2.1.5 There is a dedicated work area for maintenance activities.

13.2.1.6 Basic maintenance equipment and tools are available.

13.2.1.7 Basic technical spare parts are available.

13.2.2 The organisation implements a documented preventative planned maintenance programme for buildings, plant, installations and machinery.

STANDARD INTENT:

The organisation plans for regular in-house inspection of facilities and testing of plant and machinery to avoid hazards. The organisation's personnel may carry out the testing or the manufacturer's technicians

may carry out these tasks. Whichever system is used, the organisation has a documented plan for testing plant and machinery.

Building maintenance will include the monitoring of the following aspects:

- The general appearance of the inside and outside structure which includes the construction of walls, floors, doors and windows
- The condition of the paintwork
- Water leaks, mould spots
- Electrical wiring, for example, exposed wires, switches, electrical sockets
- Maintenance of the grounds (no litter, neat garden and grass kept short)

CRITERIA:

13.2.2.1 The organisation plans and budgets for upgrading or replacing systems, buildings or components needed for the continued operation of a safe and effective facility.

13.2.2.2 There are site and floor plans that depict the locations and layout of the main services (e.g. water, sanitation, electricity supply).

13.2.2.3 The facility has an established, documented, preventative maintenance management plan.

13.2.2.4 Regular inspections of all buildings, plant, installations and machinery are documented.

13.2.2.5 A documented procedure for reporting defects in maintenance installations during and after normal working hours is known to personnel.

13.2.3 Electrical installations are regularly inspected, tested, maintained and, when appropriate, improved.

STANDARD INTENT:

The effective and efficient operation of all key systems in the organisation is essential for patient, family, volunteer and visitor safety and for meeting patient care needs. The organisation needs to protect patients and personnel in emergencies such as system failure, interruption or contamination.

An uninterrupted source of electricity is essential to meet patient's routine and urgent care 24 hours a day. Regular and alternate sources can be used.

Critical instruments that provide required emergency services need to be connected to an emergency power system. Critical instruments are available at several different departments for example, refrigerators at pharmacy and laboratory and lights and equipment in the operating theatre and delivery room.
Critical points to be lighted by emergency power are identified and listed. These include:

- Operating theatres and recovery rooms
- Lights and sockets in the delivery rooms
- Strategic lights and sockets in ward corridors
- The neonatal nursery
- Casualty and trauma areas

Emergency electricity supplies:

- Each patient care area is provided with at least one socket outlet which is connected to the emergency power supply
- All emergency supply socket outlets are appropriately demarcated
- Emergency and backup power sources are tested

CRITERIA:

13.2.3.1 Electrical power is available 24 hours a day, seven days a week, from regular or emergency sources.

13.2.3.2 Sufficient light sources are available to provide adequate light (no dark areas) in all areas such as the entrance, waiting rooms, halls and offices.

13.2.3.3 Sufficient electrical socket outlets are provided in all areas to avoid overloading of individual outlets and to minimise fire risks.

13.2.3.4 Provision has been made for an emergency electrical supply.

13.2.3.5 There is documented evidence that relevant personnel are regularly trained to use/operate electrical supply systems and to access power in emergencies.

13.2.3.6 Servicing and testing of the uninterrupted power supplies (UPS) and/or battery backup systems are documented.

13.2.3.7 Emergency generators are tested on full load in accordance with manufacturers' specifications and such tests are documented.

13.2.3.8 Sufficient fuel, e.g. diesel, is available to provide power for 24 hours.

13.2.4 Water supplies are regularly inspected, tested, maintained and, when appropriate, improved.

STANDARD INTENT:

An uninterrupted source of clean water is essential to meet routine and urgent patient care needs 24 hours a day. Drinkable water needs to be available in all essential areas such as medical departments, wards, OPD and ablution facilities. Storage areas such as a well, storage tanks or other backup systems must be safe from contamination. Regular and alternate sources can be used.

Water quality can change suddenly due to many causes, some of which can be outside the organisation, such as a break in the supply line to the organisation or contamination of the city's water source. The frequency of water quality monitoring is based, in part, on previous experience with water quality problems. The monitoring can be carried out by individuals designated by the organisation, such as personnel from the clinical laboratory, or by public health or water control authorities outside the organisation. Records of all checks are available.

Monitoring data is collected and documented for the medical utility management programme and is used for planning and improvement purposes.

CRITERIA:

13.2.4.1 Regular and/or emergency water supplies, including drinkable water, are available 24 hours a day, seven days a week in all essential areas.

13.2.4.2 Water filters are available to remove mud and dust particles.

13.2.4.3 Should the water supply be contaminated or interrupted, the areas and services at risk have been identified and provision has been made for an alternative water supply.

13.2.4.4 There is documented evidence that relevant personnel are regularly trained to ensure that all operations to secure safe water are properly performed.

13.2.4.5 All drinkable water supplies are tested on a regular basis and the results are documented.

13.2.5 Medical gas systems are regularly inspected, maintained and, when appropriate, improved.

STANDARD INTENT:

The organisation plans its oxygen supplies according to the needs of the patients served.
Policies and procedures relating to the storage, testing and safety of gas supplies are available and are implemented.

Gas cylinders are stored in outside facilities, chained in the upright position, and have "no smoking" and "no oil" signs.

Emergency oxygen supplies ensure that:

- Where there is no piped oxygen supply, there is at least one or more mobile oxygen cylinders per ward depending on the number of beds/cots in the ward
- All the necessary fittings for oxygen are suitable for the ages of the children admitted and are working satisfactorily

CRITERIA:

13.2.5.1 Medical gas (oxygen, nitrous oxide and medical air) supplies are available according to the operational requirements of the facility.

13.2.5.2 Medical gas supply systems comply with safety standards.

13.2.5.3 Where there is piped gas, the enclosure, gas bank, pressure regulators, related control/alarm systems and all outlet points are clean and in good operating condition.

13.2.5.4 Where there is piped gas, the main oxygen supply system is fitted with an alarm which operates automatically in the event of low pressure in the gas supplies and is regularly tested.

13.2.5.5 Where there is piped gas, medical gas alarm systems are regularly tested and these tests are documented.

13.2.5.6 Backup supplies of medical gas are available and strategically positioned to ensure timely deployment in emergencies.

13.2.6 Medical vacuum systems are regularly inspected, maintained and, when appropriate, improved.

STANDARD INTENT:

The organisation plans its vacuum supplies according to the needs of the patients served. Policies and procedures relating to the testing and safety of vacuum systems are available and implemented.

Vacuum systems are regularly tested in accordance with the specifications of the suppliers. Emergency vacuum supplies ensure that:

- Where there is no vacuum supply, there is at least one or more mobile vacuum pumps per ward depending on the number of beds/cots in the ward
- All the necessary fittings for suction are suitable for the ages of the children admitted, and are working satisfactorily

CRITERIA:

13.2.6.1 Where there is a piped vacuum system, it is externally ventilated and able to provide sufficient suction to all piped vacuum points in the healthcare facility.

13.2.6.2 Piped vacuum systems are regularly tested and these tests are documented.

13.2.6.3 Alternative vacuum/suction units are available and strategically positioned to ensure timely deployment in emergencies.

13.2.7 The sewerage system is regularly inspected, tested, maintained and, when appropriate, improved.

STANDARD INTENT:

An appropriate sewerage system must be available and maintained. This will include disposal of waste water, surface water and sewage. The infrastructure, including drainage points, pipes, pumps and mains, needs to be protected to prevent spillage and contamination of the environment.

CRITERIA:

13.2.7.1 There is an appropriate and effective sewerage system.

13.2.7.2 Septic tank systems are properly managed and functional.

13.2.7.3 All drains are appropriately covered.

13.3 Medical equipment

13.3.1 Medical equipment is available and properly maintained to meet the needs of the patient population.

STANDARD INTENT:

Healthcare organisations are responsible for ensuring that appropriate medical equipment is available and ready for use at all times. There is an accountable, systematic approach to ensuring that costeffective, safe and appropriate medical equipment is available to meet the demands of quality patient care.

Managers take responsibility for ensuring that medical equipment is available, appropriately maintained and calibrated and that personnel are competent to use it.

CRITERIA:

13.3.1.1 A designated individual supervises the management of medical equipment in the organisation.

13.3.1.2 Policies and procedures guide the management of medical equipment.

13.3.1.3 The supply of medical equipment is adequate to meet the needs of the service.

13.3.1.4 There is an inventory of all medical equipment.

13.3.1.5 Records are kept of the checking and maintenance of medical equipment.

13.3.1.6 There is a documented procedure known to personnel for reporting defects in medical equipment during and after normal working hours.

13.4 Information and communication technology (ICT) equipment

13.4.1 ICT equipment is available and properly maintained to meet the needs of the services.

STANDARD INTENT:

Healthcare organisations are responsible for ensuring that appropriate ICT equipment is available and ready for use at all times. There is an accountable, systematic approach to ensuring that cost-effective, safe and appropriate ICT equipment is available to meet the demands of quality patient care.

Managers take responsibility for ensuring that ICT equipment is available, appropriately maintained, calibrated and that personnel are competent to use it.

CRITERIA:

13.4.1.1 Policies and procedures guide the management of ICT equipment.

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

13.4.1.3 The supply of ICT equipment is adequate to meet the needs of the services.

13.4.1.4 There is an inventory of all ICT equipment.

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

13.4.1.6 There is a data back-up system.

13.4.1.7 Records are kept of the checking and maintenance of ICT equipment.

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

13.4.1.9 There is documented evidence that relevant personnel are regularly trained to use/operate ICT equipment.

13.4.1.10 There is a documented procedure known to personnel for reporting defects in ICT equipment during and after normal working hours.

13.4.1.11 Computers are equipped with officially licensed software only.

13.4.1.12 Operating system patches/updates are installed as they become available.

13.4.1.13 Each computer is equipped with an up-to-date virus scanner.

13.4.1.14 Basic technical spare parts are available.

14. SUPPORT SERVICES

OVERVIEW OF SUPPORT SERVICES

The organisation may employ its own personnel to provide support services such as laundry, housekeeping and catering or support services may be outsourced, in which case the organisation delegates one or more members of personnel to supervise such contracted services.

Documented agreements exist for all outsourced services.

In organisations without an inpatient unit, food may be prepared for day care or crèche facilities. In this case, the same criteria for safe and hygienic food preparation apply.

The managers/supervisors of the services work with other organisational leaders and managers to improve the quality of service delivery throughout the organisation and to ensure that services comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

STANDARDS

14.1 Food Service management

14.1.1 The food service is managed to ensure the provision of a safe and effective service.

CRITERIA:

14.1.1.1 A written agreement is available where the service is outsourced.

14.1.1.2 A suitably qualified or experienced person manages/supervises the service.

14.1.1.3 The manager/supervisor is responsible for the day-to-day operation of the service.

14.1.1.4 The responsibilities of the manager/supervisor are defined in writing.

14.1.1.5 The departmental manager ensures that written policies and procedures are available to guide personnel in all service-related aspects.

14.1.2 There are enough suitably qualified and competent personnel to provide a safe and effective service.

STANDARD INTENT:

Orientation and induction programmes ensure the competence of personnel before they begin to carry out their functions.

Personnel act in accordance with position descriptions and are evaluated in accordance with their assigned responsibilities. The in-service training needs of personnel in the service are continuously assessed and appropriate training is provided.

CRITERIA:

14.1.2.1 Personnel employed by the organisation are managed in terms of the employer's policies and procedures relating to position descriptions, orientation and induction, in-service training and personal performance appraisals.

14.1.2.2 The manager has established an orientation and induction programme for service personnel.

14.1.2.3 Contracted personnel are managed as determined in the written service agreement.

14.1.2.4 The organisation ensures that contracted personnel are oriented to relevant organisational policies and procedures.

14.1.2.5 The organisation ensures that contracted personnel participate in relevant organisational in-service training programmes (e.g. infection control, health and safety).

14.1.3 The food service department is designed to allow for the effective storage, preparation and serving of food.

STANDARD INTENT:

The service manager needs to work closely with the organisation's managers to ensure that facilities and equipment are adequate. Management is kept informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

CRITERIA:

14.1.3.1 Where a kitchen is provided within the facility, it is designed to allow for the effective storage, preparation and serving of food.

14.1.3.2 There is a section of the kitchen dedicated to the preparation of infant feeds.

14.1.3.3 There are separate hand-washing facilities in the food preparation area, with soap and paper towels.

14.1.3.4 There is a mechanism for preventing unauthorised individuals from entering food preparation areas.

14.1.3.5 The temperature, ventilation and humidity levels are adequate to provide for satisfactory working conditions and cleanliness.

14.1.3.6 Windows in the preparation area have fly screens or another effective method of fly control is available.

14.1.3.7 There is adequate lighting.

14.1.3.8 There is a fire extinguisher and a fire blanket in the kitchen.

14.1.4 Basic hygiene measures are implemented.

CRITERIA:

14.1.4.1 The food service area meets with health and safety regulations.

14.1.4.2 Equipment, floors, walls and ceilings are kept clean.

14.1.4.3 Personnel are constantly reminded of the importance of effective hand washing (i.e. posters).

14.1.4.4 Preparation surfaces are cleaned and dried between being used for different activities.

14.1.4.5 There are adequate, clean and conveniently placed change rooms, toilets and ablution facilities for food handlers.

14.1.4.6 Food handlers have access to lockers for their outer clothing.

14.1.4.7 Enough suitable refuse containers are provided in or near each change room, handwashing facility and toilet area.

14.1.5 Menus are planned to meet patient needs.

STANDARD INTENT:

Menus are planned by a dietician or individual with acceptable food management qualifications and/or experience.

CRITERIA:

14.1.5.1 A suitably qualified and/or experienced person advises on meal development.

14.1.5.2 There is a planned weekly menu suitable for different seasons.

14.1.5.3 Wherever possible, patient food preferences are respected and substitutions made available.

14.1.5.4 Cultural preferences are taken into account.

14.1.6 Food products and meals are hygienically stored, prepared and served.

STANDARD INTENT:

Food is stored and prepared in accordance with written protocols. High-risk food which may be contaminated and which may contaminate other food is kept separately. This includes such food as meat, poultry and fish.

CRITERIA:

14.1.6.1 Potentially high-risk food, unprepared food and prepared food are kept separately from each other.

14.1.6.2 Separate cutting boards are kept for raw and cooked food.

14.1.6.3 Food is kept for a minimal amount of time after cooking and before serving.

14.1.6.4 Food waste is put in covered containers and removed without delay from places where food is prepared.

14.1.6.5 There is a mechanism for ensuring that food handlers report if they or their family suffer from diarrhoea or vomiting, throat infections, skin rashes, boils or other skin lesions, or eye or ear infections.

14.1.6.6 Food handlers wear protective clothing.

14.1.7 Food is stored under conditions that ensure security, hygiene and freshness.

CRITERIA:

14.1.7.1 Food is stored at acceptable temperatures.

14.1.7.2 Food is stored separately from non-foods.

14.1.7.3 Different types of food are kept separately.

14.1.7.4 Food is stored off the ground on racks or shelving of an impenetrable material.

14.1.7.5 Fridges and freezers can be opened from the inside through a safety release mechanism.

14.1.7.6 Stock is rotated using the "First in First Out" principle.

14.1.8 Where food is provided by families or others from outside the healthcare facility, there are mechanisms to ensure that nutrition and hygiene are maintained.

CRITERIA:

14.1.8.1 Where families or others provide food, they are educated about the patient's diet limitations.

14.1.8.2 Food is provided at regular intervals.

14.1.8.3 The food provided meets the nutritional needs of the patient.

14.1.8.4 Hygienic food preparation and serving methods are implemented.

14.2 Linen service management

14.2.1 The linen service is managed to ensure the provision of a safe and effective service.

STANDARD INTENT:

Linen management encompasses all aspects of the provision of clean linen for all patient care services. The laundry service may be provided on site or off site. Whatever system is used, the processes will be assessed in terms of the provision and distribution of linen, stock control, the collection of soiled and infected linen, laundering processes and the redistribution of linen.

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual.

CRITERIA:

14.2.1.1 A written agreement is available where the service is outsourced.

14.2.1.2 A suitably qualified and/or experienced person manages/supervises the service.

14.2.1.3 The manager/supervisor is responsible for the day-to-day operation of the service.

14.2.1.4 The responsibilities of the manager/supervisor are defined in writing.

14.2.1.5 The departmental manager ensures that written policies and procedures are available to guide personnel in all service-related aspects.

14.2.2 There are enough suitably qualified and competent personnel to provide a safe and effective service.

STANDARD INTENT:

Orientation and induction programmes ensure the competence of personnel before they begin to carry out their functions.

Personnel act in accordance with position descriptions and are evaluated in accordance with their assigned responsibilities. The in-service training needs of personnel in the service are continuously assessed and appropriate is training provided.

CRITERIA:

14.2.2.1 Personnel employed by the organisation are managed in terms of the employer's policies and procedures relating to position descriptions, orientation and induction, in-service training and personal performance appraisals.

14.2.2.2 Contracted personnel are managed as determined in the written service agreement.

14.2.2.3 The organisation ensures that contracted personnel are oriented to relevant organisational policies and procedures.

14.2.2.4 The organisation ensures that contracted personnel participate in relevant organisational in-service training programmes (e.g. infection control, health and safety).

14.2.3 Where the laundry is within the facility, it is designed to allow for safe and effective processing of laundry.

STANDARD INTENT:

Departmental managers need to liaise with organisational managers to ensure that facilities and equipment are adequate. The organisation's managers are kept informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

CRITERIA:

14.2.3.1 The space in the laundry is adequate to deal with the calculated or estimated dry weight of articles to be processed and the type of washing equipment.

14.2.3.2 The laundry provides a clear flow of laundry from the soiled to the clean side with no crossover of these lines.

14.2.3.3 The size and number of washing machines are adequate to meet the number of loads per hour, considering peak loads.

14.2.3.4 Ironers/laundry presses are adequate to ensure the processing of laundry items without undue delays.

14.2.3.5 Linen is securely stored.

14.2.4 Where linen is provided by families or others from outside the healthcare facility, there are processes in place to ensure the prevention and control infections.

CRITERIA:

14.2.4.1 There are processes that support the patient's right to bed-linen provision for comfort.

14.2.4.2 There are processes to ensure the right of the patient to dignity by the provision of appropriate bedclothes.

14.2.4.3 The family or others providing linen are guided on the type of linen that is suitable.

14.2.4.4 Personnel ensure that the family or others provide clean linen on a regular basis.

14.2.4.5 There are processes in place for the handling of contaminated linen.

14.3 Housekeeping management

14.3.1 The housekeeping service is managed to ensure the provision of a safe and effective service.

STANDARD INTENT:

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual.

CRITERIA:

14.3.1.1 A written agreement is available where the service is outsourced.

14.3.1.2 A suitably qualified and/or experienced person manages/supervises the service.

14.3.1.3 The manager/supervisor is responsible for the day-to-day operation of the service.

14.3.1.4 The responsibilities of the manager/supervisor are defined in writing.

14.3.1.5 The departmental manager ensures that written policies and procedures are available to guide personnel in all service-related aspects.

14.3.2 There are enough suitably trained personnel to provide a safe and effective service.

STANDARD INTENT:

Orientation and induction programmes ensure the competence of personnel before they begin to carry out their functions.

Personnel act in accordance with position descriptions and are evaluated in accordance with their assigned responsibilities. The in-service training needs of personnel in the service are continuously assessed and appropriate training provided.

CRITERIA:

14.3.2.1 Personnel employed by the organisation are managed in terms of the employer's policies and procedures relating to position descriptions, orientation and induction, in-service training and personal performance appraisals.

14.3.2.2 Contracted personnel are managed as determined in the written service agreement.

14.3.2.3 The organisation ensures that contracted personnel are oriented to relevant organisational policies and procedures.

14.3.2.4 The organisation ensures that contracted personnel participate in relevant organisational in-service training programmes (e.g. infection control, health and safety).

14.3.3 Facilities and equipment are adequate to provide a safe and effective cleaning service.

STANDARD INTENT:

Departmental managers need to liaise with the organisation's managers to ensure that facilities and equipment are adequate.

CRITERIA:

14.3.3.1 Adequate and secure storage areas are available for equipment and chemicals.

14.3.3.2 Chemicals for cleaning are safely stored out of the reach of patients, children and visitors.

14.3.3.3 There is adequate storage place for brooms and mops.

14.3.3.4 Mops and brooms are cleaned and dried before being stored.

14.3.3.5 Cleaning cupboards are adequately ventilated.

14.3.4 Safe waste disposal takes place according to the infection control programme.

STANDARD INTENT:

Personnel play a vital role in the removal of clinical waste from departments. Protocols need to be developed to guide personnel in ensuring their own safety, the safety of others and the safety of the environment when implementing the waste removal systems.

CRITERIA:

14.3.4.1 Waste is segregated in accordance with policies, procedures and local government bylaws.

14.3.4.2 The colour of bag and type of container appropriate to the type of waste generated are available.

14.3.4.3 Waste is protected from theft, vandalism or scavenging by animals.

14.3.4.4 Waste is collected at appropriate times so that hazards are not caused.