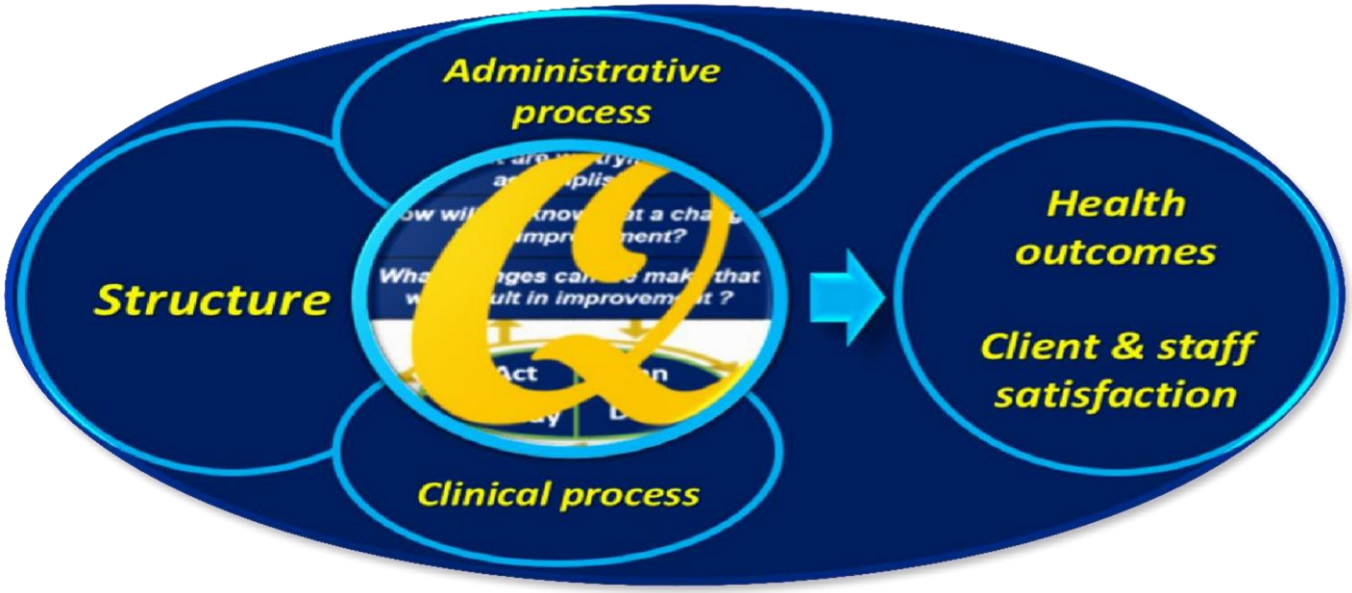
FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

MINISTRY OF HEALTH

ETHIOPIAN HOSPITAL SERVICE

Transformation Guide Line (EHSTG)



ETHIOPIAN HOSPITAL MANAGEMENT INITIATIVE

Federal Democratic Republic of Ethiopia

Ministry of Health

ETHIOPIAN HOSPITALS' SERVICE TRANSFORMATION GUIDELINE

Assessment Handbook

REVISED

June, 2018

FMOH, Ethiopia

About the Revision

Considering that there is a problem of alignment of standards with implementation guide and assessment hand book verifications, FMOH – Health Service Quality Directorate together with RHBs and some lead hospitals' staffs tried to revise the assessment hand book. The hand book helps hospitals to provide better quality services by crosschecking their performance regularly against the set standards. To make this effective, Hospitals should create regular awareness program for the staffs to oversee their respective service areas progress against the standards and take actions based on findings.

The main revision is made on verification criteria that helps to improve service quality as most criteria need to be verified by audits of MRs & prepared documents with adherence, observations, triangulation of data and possibly interview of staffs.

Some standards set as 'optional' for primary hospitals, but expected to full fill gradually focusing mainly on the implementation guide so as to give better quality of services.

CHAPTER 1: HOSPITAL LEADERSHIP, MANAGEMENT AND GOVERNANCE

KEY Points:- ***Hospital leadership, management and governance skills are essential to ensure effective, efficient and quality hospital services and good governance for health is a mission-driven and people-centred decision-making process. so hospital leaders require a unique set of skills to both manage their organization/department and to liaise with external agencies and the local community that lead them to identifying and solving any challenges to the better success of their hospital.***

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has a ***functional*** governing board (GB) meets regularly to oversee the overall operations and service delivery of the hospital.	• The board is established in accordance with a legislation • GB develop its own ***strategic plan*** discussed with possible stake holders and staffs • Governing Board(GB) develop its annual plan and Term of reference (TOR) all approved by all members • Standing committees of GB established and functional ✓ Resource mobilization/ finance committee,		

		✓ Executive/Community forum committee • GB meets in accordance with a relevant legislation at least every quarter: ✓ *Approve plan & TOR annually* ✓ ***Evaluate*** over all hospital ***performance*** including ***status*** of HSTQ/QI projects graduation as major indicators ✓ Oversee ***Feedbacks*** to the hospital from relevant bodies (***if there is)*** • Check minutes that agendas are strategic /relevant, • Check agenda set 3 – 7 days prior to meeting, ***approves*** previous meeting • Check implementations and follow up as per the ***plan*** & ***TOR*** • Check mechanisms of hospital site visit of GB with senior management team (SMT) • Check mechanisms of ***tracking*** of SMT regular activities by GB		
2.	The hospital has a ***functional*** SMT that meets regularly to manage and execute the overall hospital operations.	• Obtain organogram and check its membership include at least major department heads o Check SMT ***membership*** approved by GB • SMT develop hospital ***strategic*** plan and approved by GB & staffs • Check A***nnual*** plan discussed with community and approved by GB • SMT develop ***its own*** annual plan and TOR both are discussed and signed by all members • SMT Meets at least ***every two weeks*** on ***performance evaluation*** including ***HSTQ/QI projects***		

		• Sub committees of SMT are established (quality committee, DTC,…) and implement their functions as per the **plan** and **TOR** • Check mechanisms of SMT to identify gaps of case teams, solve and provide feed back • The SMT submits regular report to GB and relevant bodies ✓ Check GB & SMT set a schedule to evaluate hospital performance at all level in accordance with HMIS/KPIs time frame ✓ Check ***evaluation meetings & time of reports whether*** with ***HMIS and KPIs time frame*** both for GB & SMT		
3.	Hospital has a ***well-functioning*** development army.	The hospital development army established as per the guideline and check at least: • Regular 1 to 5 & Developmental Group net workings • Transformation forums conducted regularly • ***Clinical forums:*** ➢ Daily Clinical forums for Primary hospitals (***all disciplines)*** ➢ Daily clinical forums on department basis for General and above hospitals(***with composition of all disciplines***) ➢ Clinical forums with at least 1 times per week as a group (***all disciplines***) for general and above hospitals • Community forum conducted at least ***every quarter*** lead by GB chairperson (***Vice chair if not available***): ➢ Check ***saved audio- Visual*** documents with the ***date***		

		➢ Check minutes for community voices brought for discussion ➢ Check for implementations of gaps and Feed backs • Regular hospital staff forums conducted every quarter (*lead by at least a GB member other than staff representative*) ➢ Check minutes for staff voices brought for discussion ➢ Check for implementations of gaps and Feed backs • Citizen charter is prepared and communicated well to the community & staffs on annual basis(see minutes, Quality Unit activities) ➢ Check the charter whether updated at least every ***two years***		
4.	The hospital governing board has a plan to mobilize resources from diverse sources and makes sure resources are utilized effectively and efficiently.	• Check GB specific ***resource mobilization plan***, its implementation and evaluation • Check stake holders involvement (*community, NGOs, Government sectors,….)* in raising funds • Check finance/ resource mobilization committee activity whether changes in the hospital in line with the plan		
5.	There is a system and practice of measuring performance and results, appraisals and recognition system for departments and individual best performers in the hospital.	• View the BSC documents and performance expectations plans are submitted by each departments and are approved by SMT *(check minute for approval, BSC documents of individuals in 3 randomly selected service areas)* • The performance of each departments and graduated QI projects are reviewed and feedback is provided at least every 2 weeks with actions for the gaps (***check*** minutes ***and*** reports for SMT in ***3 departments***)		

		• Performance appraisals done with at least posts of best performer departments and individuals (possibly by names & photo) at least on ***quarterly basis*** after ***result approval*** by SMT and GB • A system of recognition is established for each departments and individuals best performers at least ***annually***. o Check selection criteria and possible recognition mechanisms discussed with ***staffs*** and approved by SMT & GB		
6.	The hospital SMT and GB has ethics violation reporting, complaint handling and management/reporting system.	• Check SMT orient staffs on code of conduct and CRC at least biannually • Check evaluation & reports of ***Ethical violation*** to relevant bodies (e.g FMHACA) with follow up for actions (*if there is)* • Hospital has mechanisms of complaint handling and management systems regarding Ethical &/or code of conduct violations in services area discussed by SMT every month, quarterly by GB (***if necessary***) ✓ Check awareness of ***staffs and clients*** whether there is complaint handling & management by GB & SMT		
7	The hospital has a ongoing ***capacity building*** program both for GB members and SMT	• There is a formal training & ongoing orientation program for the GB and SMT ➢ Check minutes, orientation documents addressing necessary topics ***(see appendix B in the Guide line)*** ➢ Check new members of GB and SMT receive a thorough Orientation before attending their first meeting.		

		• Assess knowledge of GB & SMT members (***at least 2 of each***) on their over a1l functions		
8	The GB, SMT & CEO is evaluated every six months consistent with FMOH or Regional Legislation to ensure meeting operational and strategic plans of the hospital	• Obtain a minute of a meeting held on self-assessment of GB and SMT conducted every six month (***team and individual basis***) ✓ Check evaluation ***tool customization (*** *in line with hospital mission*) ✓ Check GB members evaluation *held every 6 month* ✓ Check whether the CEO is evaluated by the board every 6 moth, ✓ Check SMT self-evaluation every 6 month ✓ Check the performance appraisal is submitted to relevant bodies		
		TOTAL	-----	-------
	Comments:			

CHA PTER 2: LIASON, REFERRAL AND SOCIAL SERVICE

KEY Points:- ***Effective networked health care system with properly designed and implemented Liaison, admission and discharge, referral and hospital based social services reduce patient waiting times, increase provider efficiency, staff and client satisfaction as well as improve overall quality of care.***

S.N	OPERATIONAL STANDARD	VERIFICATION CRITERIA	Met	Un met
1	The Hospital has established management structures and job descriptions which detail roles and responsibilities for: • Reception service • Liaison and referral service	A Functional Liaison and Referral service should have: • View the organizational structure • Assigned Liaison &/or referral coordinator • Check their JD which customized with their roles in EHSTG • Check assignment letter and training for staffs • Look for department annual Plan including QI activities, • Check if the hospital has reception service set near at the gate • Check reception &/or information desk for phone service, both paper and computer based registration, ….etc • Check receptionist knowledge for ✓ Clients not to be triaged ✓ Familiarity toward service areas and Type of services they provide ✓ Information about admitted patients and service providers, … • Regular performance review including indicators in the chapter, verifying before report AND identify gaps with QI project and actions plan		
2	The hospital should provide liaison services 24 hours in a day throughout the year.	• Check continuity of service in 5 emergency admissions and 5 IPD discharge cards from registration during weekend and calendar days in the last quarter that they go through liaison unit ✓ Referral ins and outs (referral documentations vs liaison registers) ✓ Admission service (Inpatient registers vs liaison registers) ✓ Discharge service (Inpatient registers vs liaison registers) ✓ Daily Bed census including weekends and calendar days • Verify if appointment system ***considers*** priority/ criteria on: ✓ Severity/disease progress, ✓ Geography , ✓ Finance and social conditions of patients		

3	The hospital has a written protocol for the admission and discharge of patients that is known, and adhered to, by all relevant staff.	• Check for hospital specific admission and discharge protocol ○ Interview 5 staffs from different service areas for their knowledge and adherence • Check admission criteria and ask what was done prior to admission on 5 patients in IPD • Check staffs training and orientation on liaison, social, referral,…. services		
4	The hospital has a Referrals Service Directory, listing facilities which the hospital may refer patients to or receive patients from, categorized by the type of clinical services they provide.	• Check for availability of ***annually revised*** service directory ***and*** referral network of facilities (agreed between referring and receiving facilities) *at least with in the zone/region* • Check communication system b/n facilities before referring out/in clients for better follow up care • Hospital develop and practice inter department referral protocol signed among departments • Check on 3 senior physicians,2 GPs, 1IESO for protocol adherence		
5	Criteria for the referral of patients from the hospital to other health facilities are established in accordance with the national referral implementation guidelines.	• Check for availability of referral criteria developed and approved by hospital(*inter department & out of the hospital*) • Check availability of standardized referral and feedback forms (*with* ***in/out*** *of the hospital*) • Check on 3 senior physicians,2 GPs, 1IESO for adherence		
6	The hospital has a standardized method for managing referrals and staff members are familiar with the referral systems including relevant referral protocols and forms.	• Check hospital providing full liaison service packages • Check liaison service packages are audited regularly(*referral, bed management, appointment, A & D)* interview 5 relevant staff on their knowledge on liaison service ***packages*** • Check the system of communication among professionals during referring clients (*including online consultations,)* • Check for mechanism to truck referral feedback (take 5 referred clients' card and feedback attached or registered at liaison unit in the last quarter(*both in and out*) • Check mechanism to monitor referred cases.(*take 5 referred clients in the previous week from the liaison unit & what information at hand about referred clients)* • Check for actions &/or QI projects on liaison service package audit findings		

7	The hospital promotes and publicizes the referral system throughout the community in order to ensure that all constituents are aware of the applicable service pathway.	• Check minutes the system discussed during THM as an agenda • Check Adio –Visual document and leaflets used for publicize referral system • Check with 5 selected CBHI service beneficiaries and 3 referral ins whether they have problems they face on referral service • Check orientation given to the staffs on referral system(*among departments & out of hospital*) • Check mechanisms to discuss about referral system among HFs at least in their cluster meeting		
8	The hospital has established hospital based social service which addresses the social care needs of patients affecting the efficient and effective flow of patients.	• Check if the hospital has social health services for the needy work integrated with the liaison office • Check Hospital set customized JD (individual & department) • Check social service plan that the plan includes identified source of support and agreed with stake holders • Documented evidences for specific service provided by Social Worker including case Mx, counseling, psychotherapy,…etc		
	Comments:	**TOTAL**	**-------**	**-----**

CHA PTER 3: EMERGENCY MEDICAL SERVICES

KEY Points:- Emergency Medical Services (EMS) overall are a network of services and resources coordinated to provide aid and medical assistance from primary response to definitive care that can be given in a pre-hospital or hospital setting addressing all the domains of Acute Care to save lives.

S.N	OPERATIONAL STANDARD	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has an emergency department led by an emergency director / case manager with customized JD for the department and individuals.	• View the organizational structure, annual and QI plan • View customized JD (*department & individuals*) • Focal person assigned for oxygen supply and management for emergency service areas work with other stake holders in the hospital (*Finance, General service*) • Regular service area performance M& E including indicators in the chapter with identified gaps, QI projects, • Emergency death audit gaps and actions taken (*mainly of 3rd delay)* • Check adherence of front line staffs to all activity including nursing/midwifery service management for all those admitted more than 24 hrs • Check nurses assess and manage the 4 P's for critical patients (***Pain, Position, Posy and Possess***) • Runners/porters trained at least on transport of samples & requests, patients, confidentiality of Pt. information, …..) • Check assignment of security guard, runners, patient assistant,..	`	
2.	The hospital has an Emergency Triage, staffed with necessary infrastructure, appropriately trained personnel and equipped with necessary equipment, drugs and supplies needed to provide quality emergency medical services.	• Check dedicated area/room for emergency triage • Asses the availability of drugs and equipment (see annex) • Staffs are trained to conduct emergency patient triage and emergency care (*check certificate*). • Check regular emergency supply stock monitoring and handover during each shift • Check for availability of pulse oxiymetry, oxygen concentrators, gas analyzer (optional for primary and general hospitals), • Check document all oxygen cylinders cleaned at least every year		

		• Oxygen plant at least in major wards, ICU, OR and emergency (***for specialized hospitals***)		
3.	The hospital has easily accessible Emergency department with an ambulance parking area.	• Hospital has ***separate gate*** (***optional for primary hospitals)*** with trained receptionist(at least BLS, IPPS,…. with reflective jacket) • ER unit is labeled properly and visible from the distance including night time (red background with white notes, illuminated, multi lingual) • Check the department near to the gate, easily accessed/ground floor • Check mechanism of communication and ambulance utilization management - among departments and facilities • Check isolate ambulance parking area (*visible at night*)		
4.	The hospital shall establish efficient flow of Patients in the emergency department.	• Confirm that the emergency unity is organized based on the following areas; (***optional for primary hospitals, but it is mandatory to avail all services***) • Patient assistant area at Emergency gate with supplies • Triage area • Waiting area for non-critical emergency patients • Examination area • Isolation room • Resuscitation area • Procedure area • The observation and treatment area(beds for 24hrs) • Emergency OR (***for primary hospital easy access to main OR***)		
5.	The Emergency Department/Unit shall use a triage system of screening and classifying patients to determine their priority needs and to ration patient care efficiently.	• Observe separate pediatric and adult triage area (*optional for primary hospital)* • Observe at least ***color coded rooms*** to prioritize patient care for adult and ETAT based triage for pediatric • Regular patient acuity level assessment with Triage formats attached ✓ Confirm 6 MRNs (3 adult and 3 pediatric) from HMIS		

		register in the last quarter, retrieve the charts and verify all of the following: o Triaged within 5 minutes of arrival o The patient is appropriately classified as per the severity with appropriate and timely management		
6.	The hospital provides emergency medical service 24 Hours a day with a 24-hours' access to diagnostic laboratory, radiology and pharmacy services.	• 24 hr emergency Pharmacy service (*check 3 randomly selected emergency prescriptions/sale tickets in the last quarter and drugs availed from ED on date of order*) • 24 hr emergency Laboratory service – (*check 3 randomly selected emergency Lab. requests from ED register in the last quarter and tests are done in ED Laboratory*) • 24 radiology and ultrasound service (*for primary hospitals: 24hrs access to main X-ray and U/S with a prioritization mechanism for emergency patients)* ✓ Check 3 randomly selected emergency X-ray/Ultrasound requests in the last quarter done on the date of order) ✓ Check mobile x-ray for general and above hospitals		
7.	There is emergency response plan for both internal and external disasters with a system to alarm or communicate personnel and other stake holders.	• Check the assignment of emergency response coordinator (incidence officer) and ask his duty in case of disaster • View comprehensive emergency response ***plan*** of the hospital and verify if the plan includes a mechanism to: ✓ Mobilize for more human resource from within or outside the hospital ✓ Avail more drugs and supplies and even share other resources with other departments within the hospital itself • Check orientation given to the staffs and their adherence including call from home to manage disasters during duty hour		
8.	Emergency department or Unit has policies, protocols, flowcharts, consultation and treatment guidelines for running ED/EU.	• View presence of policies, protocols, flowcharts • Check Consultation communication guides among professionals and departments and adherence among staffs • Check Treatment guidelines (ETAT, Adult and Pediatrics,….) • Check availability of oxygen administration and management protocols and SOP based on the client needs, monitoring,…		

		TOTAL	___	___
	Comments:			

CHA PTER 4 OUTPATIENT SERVICES

KEY Points:- ***outpatient services management refers to the processes and procedures needed to ensure the efficient flow of patients between the patient's first encounter with the reception until the patient exits resulting in reduced waiting times, improve service quality and client satisfaction.***

S. N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The Hospital has established management structures and job descriptions that detail the roles and responsibilities of each discipline within departments/units, including reporting relationships.	**A functionally running outpatient department should have all of the following**: • Check organogram, Annual and QI Plan cascaded to front line staffs • Clearly customized JD (*department and individuals*) prepared • Regular service area performance M& E action plan • Check QI projects are designed and cascaded based on gap analysis • Runners/porters trained at least on transport of samples & requests, patients, confidentiality of Pt. information, …..)		
2.	The hospital has well-equipped service specific OPD rooms with necessary equipment and supplies as per hospital tier level of care	**Verify for all of the following:** • Adequate number of OPDs arrangement (*based on the daily outpatient attendees, number of physicians and OPD waiting time data*) • All OPDs are well equipped as per standard • Specialty and subspecialty clinic arrangement based on the hospital level • Check availability of procedure rooms near to OPDs		
3.	The hospital has established outpatient specific diagnostic laboratory, radiology, and pharmacy service units.	• Functional Outpatient laboratory -> Check 3 randomly selected Outpatient lab. requests in the last quarter **all done** on the same day of order • Functional outpatient pharmacy -> Check 3 randomly selected Outpatient prescriptions in the last quarter **all** dispensed to the Pt. on date of order • Functional radiology and imaging unit - Check 3 randomly selected imaging requests in the last quarter all done/availed in the Hospital on the day of order • Check Sample collection unit for Laboratory rooms		

4.	The hospital has an outpatient department waiting area with adequate lightening, ventilation and multimedia facilities.	• Check availability of adequate waiting area (in comparison with volume of patient) • Waiting area is clean, ventilated, lightened • Separate waiting area for pediatric and adult (***optional for primary hospitals and they should have at least separated corner in a room***) • Multimedia service for Health Education is available –like TV, Radio,. • Check Chairs/ client sits are comfortable • Check there is Isolated ***waiting area*** for coughers/ Pts with CDD		
5.	The hospital has an OPD service specialty clinics by a service specific specialist, sub- specialty clinic by sub specialist as per hospital tier level of care.	• Check clinics arranged and run as per specialty/seniority • All referred patients including ANC seen by next level professional (*Check 5 randomly selected referred in clients from referral in registration seen by next level of profession at his/her first encounter)*		
6.	Outpatient department (OPD) specific central triage procedure is established to ensure efficient patient flow; and seek to reduce patient crowding.	• Protocol for managing queue at triage • Registration for patients not seen on the same day (***from all possible sites***) • Observe MR, Pharmacy and Examination areas if there is no crowding • Check registration system of referred - in clients in the triage room • Check availability of necessary supplies for triage service • Procedure for prioritize clients based on their time of arrival at triage • Check procedures to be taken for clients who need emergency service		
7.	The hospital has established OPD patient registration and appointment systems	• Check OPDs appointment system go through liaison • Check OPD appointed clients directly go to specific service areas without being triaged on the day of their physician visit • Check MR retrieval of appointed clients one day prior to clients' appointment day • Verify OPD appointment system considers priority on severity, geography, finance and social conditions of patients(*if need arises*)		

	Comments:	**TOTAL**	__	---

CHA PTER 5. INPATIENT SERVICE MANAGEMENT

KEY Points:- The purpose of the inpatient service is to provide safe, comprehensive, interdisciplinary assessment, stabilization, treatment, and services to ensure that the patient can resume normal community living as soon as feasible, thereby maintaining independency with possible short stay without harming his/her outcome.

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The Hospital has established management structures and job descriptions that detail the roles and responsibilities of each discipline within departments/units, including reporting relationships	**A functionally running inpatient department should have all of the following:** • Check organogram, annual and QI plan cascaded to front line staffs • Check customized JD (for the department and individuals) • Focal person assigned for oxygen supply and management work with other stake holders in the hospital (Finance, General service) • IPD assigns focal persons(IPPS -CASH, data management, …..) • Regular M&E/ audit conducted as per the schedule with action points • Check there is a system of data verification prior to reporting • Check QI projects are designed and cascaded based on gap analysis • Runners/porters trained at least on transport of samples & requests, patients, confidentiality of Pt. information, …..) • Check assignment of security guards, runners, ….		
2.	IPD specific admission and discharge procedures are established to reduce the unnecessary inpatient length of stay.	• Check admission and Discharge Protocol • Select 5 patient chart in the last quarter from weekends and check clients go through liaison office, completeness of Discharge summary		
3.	All admitted patients have medical and nursing/midwifery care plans that describes medical and nursing/midwifery interventions to address their needs.	Randomly take 5 charts and • Check mechanisms of patient orientation soon after admission to all clients • Check history sheet revised immediately for critical patients ***or*** within 2 hrs of admission for stable patients • Progress note written/updated at least daily till discharge of patient • NSG assessment and evaluation done at least daily		

		• Order sheet is revised at least daily, fluid balance monitoring ,… • Check discharge counseling is team based(physician, pharmacist, nurse) and recorded in the chart • **Check** discharge summery **is attached and completed** • Check O2 administration protocol and SOP, O2 ordered by physicians, saturation monitoring and recording,…. • Check policy for dead body care and its discharge management which address; o Confirmation of death o How to inform family with religious and cultural considerations o Death summary o Need for pathology and examination with necessary forms,….		
4.	The hospital implements a minimum of daily multidisciplinary team patient rounds and visit services.	• Check round protocol and its adherence • Check round lead by seniors in each department and conducted daily including calendar days • Check teaching and MDT regular ward rounds scheduled separately • Check round schedule and its team composition (of Lab. professionals, clinical pharmacists, dietitians(*optional for primary hospitals*)		
5.	The Hospital has IPD service specific facilities as per hospital ***tier level***.	• Hospital prepare policy and procedure for specialty services • Check at least a trained professional in ICU service • Hospital provides ICU service with necessary supplies (*at least high dependency unit, HDU for primary hospitals*) • Check Mental health service availability in the hospital		
6.	The hospital has IPD staffed with adequate personnel with necessary equipment and supplies for Inpatient as per tier level of care	• Check work force plan availability in IPD at least for nurses • Check availability of rest room for duty staffs with necessary commodities • Check assignment and availability of on duty physicians during the whole duty hours • Check assignment of HWs in fulltime (senior physicians, clinical pharmacist,..) during working and duty hours • Check IPD equipment's and supplies as per tier system(see annex) • Check in all IPDs including OR, ICU, delivery for availability of pulse oxymetry, oxygen concentrators, gas analyzer(*optional for primary and general hospitals*), • Check with document whether all oxygen cylinders cleaning at least every year		

		• Oxygen plant at least in major wards, ICU, OR and emergency (***for Specialized hospitals)***		
7.	The Hospital has established guidelines for verbal and written communication about patient care, including verbal orders and patient handover by discipline and between disciplines	• Check Communication guideline (verbal and written, intra and inter professional, intra and interdepartment) with evidences • Interview 05 staffs(3 nurses and 2 physicians) from different departments knowledge about the communication ways between staffs and service areas • Check Shift hand over protocol and practices with evidences		
8.	The Hospital has established procedure for and inter professional and departmental consultation and transfer of patients' care to ensure continuity of care.	• Check Consultation protocol and practices with evidences • Check practice/knowledge by interviewing 5 personnel(2 physicians and 3 nurses) from different departments		
9.	The Hospital has a policy for accompanying all patients by appropriately trained health provider/s during out of IPD diagnostic services and transfer between wards/departments.	• Check Patient transportation protocol and assigned personnel (inter - intra facility of both stable and critical patients • Observe patient transportation and ask 5staffs(2 physicians and 3 nurses) on knowledge of the protocol and practice • Interview 05 admitted patients need transportation from different departments about their experience during need of transportation		
		TOTAL	__	___

Comments:

CHA PTER 6. MEDICAL RECORDS MANAGEMENT

KEY Points:- ***Medical Record Management (MRM) is critical to improve the provision of continuum of quality health care services, ensure safe medical practice , improve the patient's experience and satisfaction with their medical encounter. It helps also to make clinical and public health evidence based practices, making informed decisions and used as reliable source of information for medico-legal issues and medical/ public health researchers.***

S. N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	Unique medical record number is assigned to a patient during his/her first visit of care.	• Select randomly 10 MPI cards of the previous years and confirm: o They registered in the computer/smart care/, each MR number unique to a client, properly kept and easy to retrieve		
2.	The hospital shall have a single unified medical registration unit for all patients' registration.	• Confirm that only one registration system exists for ALL patients • If there is separated registration on service categories with in the unit, ensure the system is interconnected for numbering of MRs • Take 5 tracer cards and Check availability of their correspondent MRs in the hospital • Check supplies and electric system is available 24 hr in the MR room		
3.	The hospital utilizes paper and computer-based systems to register and retrieve medical records.	• Observe the utilization of both manual and computer based MPI for 24 hour • View MR tracking system whether computer and/or patient service card used o Take 5 MR from registry and check time of retrieval whether with in the standard		
4.	The hospital avails and utilizes a standard set of formats that comprise a complete medical record for continuum of patient's care.	• Hospital set standard/policy for patient formats filing in the folder • Randomly sample 10 inpatient medical records admitted in the past year, and confirm that each, as a minimum: ✓ All forms in the client folder are of same (A4) size ✓ Check formats with in the folders are well attached and intact ✓ Check formats in the folders attached in orderly manner according to hospital policy		

5.	The hospital shall implement and comply with national guidelines to manage access to patient's medical records.	• Interview medical records staff and confirm national guidelines on handling and confidentiality of medical records are known by all staff. o Confirm if there is separate locked MR store available for medico-legal cases with proper hand over. • Check Staff orientation on confidentiality of MRs, MR access policy,…		
6.	The hospital performs medical record auditing, data quality checks, archiving/culling procedures and takes corrective actions on a regular basis.	• Check MR audits at least biannually to check/focusing on : ✓ Patient folders missing from the shelf ✓ Summary sheet of each folder for all visit are dated and filled properly ✓ Complete ness of formats (each formats with authentications) ✓ Availability of tracer card in each folder, ✓ Check actual MRs archived or destructed etc ✓ View audit reports &documented evidence that shows action taken based on audit findings, ✓ See M & E of indicators in the MR chapter ✓ View proper shelving of medical records ✓ View store prepared for archiving of MRs (inactive for more than 2 years)		
7.	The hospital ensures patient's medical records return from different service units to medical records unit at the end of each service day in accordance with medical record tracing system.	• Check tracer card prepared to all client folders • Confirm there is daily balance done for MRs distributed at OPDs with the return at end of each service day • Check mechanisms to return MRs of admitted clients with in 24 hrs of discharge • Check handover system of MRs b/n MR department and service areas • Check communication mechanism to completeness of MRs among Service areas > liaison office > MR department		
8.	The hospital shall automate health information system through implementation of integrated electronic medical record system.	• View and confirm implementation of integrated electronic medical record(eMR) systems in the hospital ✓ Check service areas for functionality ✓ Check back up systems (UPS, 24 hr Electric supplies, …..)		
		TOTAL	___	___

Comments:

CHA PTER 7. NURSING AND MIDWIFERY CARE SER VICES MANAGEMENT

KEY Points:- ***Nurses and midwives are professionals who are committed to the development and implementation of standardized practices through ongoing acquisition, application and evaluation of knowledge and skills. Nursing and midwifery services are expected to provide people centered continuum of care with competent, safe and ethical care in fully accountable and responsible manner for their entire practice through which they needed most to improve the health outcomes of individuals, families and communities in general.***

S. N	STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has established nursing midwifery service management structures and job descriptions that detail the roles and responsibilities of each nursing and midwifery professional, including reporting relationships.	• Check for nursing midwifery representation in the SMT; • The hospital established management structures that detail the roles and responsibilities of nursing midwifery professionals with customizations of JD as a group/ individual including reporting and communication relationships • Check operational plan approved by SMT with ***its implementation*** regarding: ✓ Nursing midwifery practice to ensure quality ✓ Capacity building of students toward holistic nursing midwifery services ✓ Follow up on competency on patient care with stake holders ✓ Nursing midwifery day to day learning sessions/peer reviewing using ▪ In service training ▪ Grand round ▪ Journals reading and update each other ▪ Online searches related to practices and update each other ▪ Discussions with colleague		

2.	The hospital has a nursing and midwifery workforce plan that addresses nurse /midwife staffing requirements and sets minimum nurse /midwife to patient ratios in each service area.	• Obtain copy of nursing midwifery staffing plan and confirm this establishes nurse/midwifery to patient ratios for each service area • Confirm the plan identifies mechanisms to reassign nursing/midwifery staff or call in extra staff to ensure that minimum nurse/midwife to patient ratios are maintained • Check there is Orientation and f/up mechanisms during transfer of nurses/midwives in clinical settings		
3.	The hospital has written policies describing the responsibilities of nurses and midwives for the nursing/midwifery process including the admission assessment, planning, implementation and evaluation of nursing/midwifery care.	• Identify written policies that describe the nursing midwifery process. • Verify that the following are addressed: ✓ Nursing midwifery admission assessment ✓ Nursing/midwife care planning, implementation and evaluation for all admitted patients		
4.	All admitted Pts and mothers and emergency patients/clients have a nursing/midwifery care plan that describes holistic nursing/midwifery interventions to address their needs.	• Select a random sample of 5 emergency and delivery ward cards(***stay >= 24 hr)*** and Confirm that each contains a complete nursing care plan, medication records including oxygen, order sheets including oxygen,…. **all** updated regularly • Select randomly selected 5 IPD cards and Confirm that each contains a complete nursing care plan, medication records including oxygen, order sheets including oxygen,…. updated regularly		
5.	All hospital nurses/midwives comply with the professional code of conduct and ethics which governs their professional practice.	• Does the hospital provide a written professional code of conduct and ethics to all nurses and midwives? • Does the hospital provide complete uniforms for nurses/midwives and do they comply with National/Regional dress code all the time • Does the hospital have a system to evaluate and report illegal, incompetent or impaired practices to relevant bodies? • Check 5 randomly selected nurses/midwifes for awareness of their code of conduct • Check 5 randomly selected clients for awareness of uniform coding of hospital nurses/midwifes • Do nurses and midwives implement CRC(using HSTQ)		

		✓ Check by interview clients from different wards for CRC practice		
6.	The hospital has established guidelines for verbal and written communication about patient/client care that involves nurses/midwives and their patients/clients, families, other case team professionals of the disciples, including verbal orders and timely documentation of accomplished activities.	• Does the hospital provide written guidelines regarding verbal and written communication and documentation? • Do nurses and midwives seek constructive feedback regarding their own practice from hospital management/QU/? • Does the hospital/nursing midwifery management have a systematic of peer review? (***Senior nurses supervise, mentor and coach regularly to support the junior nurses***)?		
7.	The hospital has standardized procedures for the safe and proper administration of medications by nurses or designated clinical staff.	• Does the hospital prepare ***central/room cabinet*** to ensure medications are not placed at patient side? • Identify written procedures for process of medication administration. • Verify that procedure addresses safety, proper administration, and administration authority. ✓ Check Oxygen prescribed, administered and monitored as vital sign (***for the needy only)*** • Review 10 Medication Administration Records (***03*** *MRs with oxygen administration*) from different wards and confirm that each is completed correctly with the signature of the transcriber and of the individual who administered each medicine dose.		
8.	The hospital has established nursing/midwifery care practice audit program, including the documentation of completed audits and resulting practice improvements.	• Does the Hospital have a Nursing/midwifery Audit Committee? • Does the Nursing/midwifery Audit Committee meet regularly and conduct a nursing/midwifery service audit?(*check with TOR, Plan, HSTQ*) • Do Nurses/midwives participate in *death review* to improve the quality of healthcare? • Do Nurses/midwives collaborate with the inter-professional team (CRC,QU,…) to implement quality improvement plans • Do Nurses/midwives incorporate evidence based best practices (collect data, analyze trends,….) including chapter indicators to improve health outcomes? ✓ Look for a nursing/midwifery audit report and follow up		

		✓ Look for action plans to implement gaps identified by audits		
9.	The hospital implements nursing/midwifery eight hours' shift and regular rounds	• Is the hospital implementing 8 hours shift of nursing/midwifery service? • Do the nursing/ midwife staffs conduct all types of rounds (shift round, individual/1hr, group nursing and grand round) ? o Check adherence to the protocol/guide line • Check nurses & midwifes do hourly round for ***critical ill*** patients addressing the 4 P's (***Pain, Position, Potty and Possess*****)**		
10.	The hospital has a centralized nursing/midwifery station set-up in each ward with adequate space, equipment and consumables.	• Does each unit have the necessary equipment and supplies to accomplish nursing and midwifery care practice? • Does the unit have equipment for specific minor procedures? • The station should have necessary guide lines, reference materials,… • Station should have facilities for refreshment to on – duty staffs		
		TOTAL		
	Comments:			

CHA PTER 8. MATERNAL, NEONATAL AND CHILD HEALTH SERVICES MANAGEMENT

KEY Points:- ***Nurses and midwives are professionals who are committed to the development, implementation/ practice of standards to ensure highest quality of care during antenatal, delivery and postnatal periods targeting essential maternal and newborn care and management of complications that could achieve the highest impact on maternal, fetal and newborn survival and well-being.***

S. N	OPERATIONAL TIONASTANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital ANC unit provides individualized, client centered and evidence based care to clients on all working days and high risk mothers should be seen in the referral clinic.	• ANC unit is established under outpatient department and a unit coordinator is assigned with customized JD • ANC service is provided during all working hours of working days • There is a mechanism to screen high risk mothers and provide care by the senior health care providers in all working days of the week (IESO or Obstetrician in nonteaching hospitals, final year resident or obstetrician in teaching hospitals) • Focused ANC service is implemented (according to guide line, regular orientation for midwives at least biannually) • Check both visual and auditory privacy is maintained • Check all referred mothers seen by higher level of profession(from referral registration) • Check all MNCH services monitored and evaluated including chapter indicators related to plan and action taken to identified gaps • There is a mechanism to facilitate and prioritize pregnant women for hospital services like laboratory services o Check Lab. TAT for pregnant mothers o Lab. and MCH staffs awareness on prioritization,…..		
2.	The hospital should ensure provision of Comprehensive Emergency Maternal and Newborn Care (CEmONC) services	• Interview the maternity head if all CEmONC functions are available all the time • All surgical teams including obstetricians are on duty and stay in the hospital compound during duty hours • Safe surgical checklist and standardized operation note and register documentation is used for ***all*** major surgical interventions • Verify service provision through Chart audit from the previous quarter performance – select 5 MRN from HMIS operation register and – verify if:		

		✓ Safe surgery checklist is properly filled, ✓ Operation note includes at least date of surgery, time of skin incision, ✓ Identification of client including her MRN ✓ List of names of all surgical team,– surgeon, assistant anesthetist/anesthesiologist, scrub, runner, ✓ Preoperative diagnosis, ✓ Type of procedure, ✓ Postoperative diagnosis, ✓ Intraoperative findings, ✓ Description of procedure, ✓ Instrument/pack/gauze count,…. etc		
3.	The hospital should ensure women and child friendly services at all MNCH units including pain management.	• Rooms should be well ventilated and temperature of the room should be good (neither hot nor cold): • The rooms should have a working bath room and toilet with door that is accessible to laboring mothers that has a hand washing basin with soap and water for both labor and post-natal ward: • Family member/support person is allowed to remain with woman constantly during labor and birth (interview 3 mothers) • Mother is offered oral fluids and light food during labor and allowed to deliver in their preferred position (interview 3 mothers • Adequate Pain assessment and management is practiced(check whether scoring pain used as 5th vital sign)		
4.	The hospital ensures all equipment, essential drugs, supplies and reference materials are available in maternity and pediatric units	• See annex o; MNCH QI assessment tool or annex 1, 2, 4, 5, 6, 7, 8, & 9 on MNCH service chapter on EHSTG.		
5	The hospital should ensure the provision of intra-partal care as per national protocols	• Adequate number of active first stage beds (at least 4 for primary hospitals and 8 and above for general and tertiary hospitals) • Adequate space for walking • Adequate number of second stage couched (at least 2 for primary hospitals and 3 and above for other hospitals) • Well-equipped newborn corner in delivery room (radiant warmer, ambubag **# 0/1**, suction materials(bulb & machine), posted basic and advanced neonatal resuscitation flow **chart**) • Midwifes assess and manage the 4 P's for critically ill patients (***Pain, Position, Posy and Possess***) and Pain management for all mothers and children (at least with burn, surgery, Ca).		

		• ***All nursing and midwifery assessment done for all mothers admitted for more than 24 hours*** • Chart audit from previous month performance (select randomly 5 MRN from delivery register in the quarter and verify if the following information are available:– ✓ Pantograph filled correctly/ decisions are appropriate and timely, ✓ Delivery summary filled, ✓ Safe child birth checklist filled correctly, ✓ Neonate provided at least with OPV 0/BCG/Vit K, TTC eye ointment)		
6	The hospital should provide comprehensive postnatal care in the facility as per national standards	• Postnatal ward is clean, well ventilated with good temperature (nether hot nor cold) • Chart audit of previous month performance (select 5 MRN randomly from postnatal register in the quarter and verify if maternal V/S monitored every 30min for first 2hrs and then every 2hr till discharge) • Family planning counselling for all pregnant women with a focus on long term methods		
7.	The hospital should ensure provision of family planning (with focus on long term methods) and comprehensive abortion care services following the national guideline and policies.	• Established CAC unit (separate or with emergency obstetric OPD) • Established FP clinic • Trained health professional were assigned to provide counseling on contraception, unintended pregnancy and abortion; • Demonstrate competent skills and the services should be evidence based: • Comprehensive health and obstetric, gynecologic and reproductive health history taken and physical examination done: • Care, support and referral or treatment for the HIV positive woman and HIV counselling and testing for women who do not know their status provided: • Prescribe, dispense, furnish or administer a broad range of contraceptive methods, including IUDs, implants, injectable emergency contraceptives and women advised about management of side effects and problems with use of family planning methods: • Perform vacuum aspiration (manual or electric) for pregnancies of gestational age up to 12–14 weeks according to the national guideline.		

		• Medical methods of abortion available for pregnancies of gestational age up to 9 weeks, or up to 12 weeks if the woman can stay in the facility until the abortion is complete according to the national guideline; • Clinical stabilization, provision of antibiotics, and uterine evacuation provided for women with complications of abortion; • Referral women who needing unavailable services in the hospital or HCs.		
8.	Maternity and pediatric units should undertake CQI activities by conducting regular review meetings and audit programs.	• Quality improvement team established • Regular clinical audit including maternal and neonatal death audit as per HSTQ that is done monthly, gaps and actions taken • Client/pregnant mothers' forum conducted quarterly (look for minutes, documents, photos etc; verify if action plan prepared and implemented following each forums)		
9.	Hospitals have established separate pediatric OPD, emergency and triage services.	• Pediatric OPD is separate from adult OPD • Established separate pediatric triage(*optional for primary hospitals with priority for pediatrics if less case load*) and adjacent emergency treatment area (room) within pediatric OPD and system of triage established before registration • All the necessary human resource trained on ETAT, equipment, drugs and supplies, guidelines and job aids are present (See annex 1 and 3) • ETAT is established (select 5 MRN from emergency pediatric register or ETAT register and verify if triage form showing appropriate triage and management is attached)		
10.	Hospitals have comprehensive Neonatal Care service that includes NICU, KMC, mother's room and isolation rooms.	• Presence of established neonatal unit composed of at least NICU separate for non-communicable and communicable diseases, KMC room, mother's waiting room. • Neonatal care given by appropriate personnel (neonatologist/pediatrician; in the absence of these, other HCPs may provide the service if they do have special training tailored to neonatal care and problems related to neonates; in which case look for evidences of training or orientation like certificates, training materials etc) • All essential equipment, drugs and supplies present (see annex 2) • All guidelines and job aids present (see annex 3)		
11.	Hospitals have separate Pediatric Wards composed of separate critical, general, SAM, isolation and procedure rooms.	• Check that the hospital has pediatric ward separate from adult ward • Check that the pediatric ward is composed of the following rooms: - Therapeutic feeding room for children with complicated SAM - Pediatric ICU or at least HDU for critically ill children next to the nursing station		

		- Isolation room for children with communicable diseases (*in primary hospitals, this may be shared with procedure room for adults*) - Clean, ventilated procedure room with good light source (*in primary hospitals, this may be shared with procedure room for adults)* • All ward room paintings are child friendly • Confirm the presence of national guidelines and job aids listed in Annex 3, and supplies and equipment listed in Annex 6 are available and functional • From 3 charts in the quarter, check the following: - Children admitted to the wards are evaluated by physicians (preferably pediatricians) on daily basis (twice per day for critical children) - Critically sick children are evaluated by registered clinical nurses every 4 hours • Vital signs are measured every 6 hrs for admitted children (more frequently if ordered by a physician) - Growth monitoring is performed for *all U5* children admitted to the ward • Admission and discharge notes, vital sign sheets, and discharge or death summaries are attached to the patient charts • Nutritional screening for ***all age*** groups according to the guide line • Pain management at least those with burn, surgery, cancer		
12.	Midwives should implement the midwifery process at all hospitals for all admitted patients.	• Chart audit from previous quarter (select randomly 5 C/S charts from delivery register and 5 MRNs of high risk mothers cared in maternity ward from admission discharge register and verify if midwifery process was done for all charts (note that midwifery process form is as per EHSTG nursing/midwifery process format)		
		TOTAL		
	Comments:			

CHA PTER 9. LABORATORY SERVICES MANAGEMENT

KEY Points:- ***Laboratory services strengthen the practice of modern medicine by providing information to end users to accurately assess the status of a patient's health, make accurate diagnoses, formulate treatment plans, and monitor the effects of treatment.***

S. N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has a clear laboratory management structure and accountability arrangement with well-defined roles and responsibilities for the provision of laboratory services organized into central, emergency and inpatient laboratory services.	• View organization chart, clear JD of the department and individuals set by the hospital with customization. • Check assignment of full time quality and safety officers • Check central laboratory controls laboratory services in each department (minutes, reports, ..) • Check laboratory staff competence assessment management structures set in the hospital • View central, emergency and inpatient laboratories functionality: ✓ Check 5 randomly selected OPD lab. requests done during working hrs on the day of Order ✓ Check 5 randomly selected emergency lab. requests from ER registration that is done during emergency hrs in ER laboratory ✓ Check 5 randomly selected IPD laboratory requests done at IPD lab. on the day of order		
2.	The hospital laboratory management has established system for management of documents and records that are maintained, controlled, reviewed and approved to ensure the provision of quality laboratory services.	• Obtain evidence for document and record generation, identification, approval, use, control and disposal procedure ***with practice*** • View the laboratory-produced ***updated*** quality manual, safety manual, sample management guideline ***with practice,….*** • Confirm the availability of standard operating procedures for all Technical and Managerial procedures in all service areas at work place • Confirm the availability of ***updated*** Guidelines, Formats , Job aids and instructions in work place • Check all Lab. staffs involved in preparation of all necessary documents		
3.	The hospital laboratory has established system to monitor the effectiveness of its customer service program.	• View pocket sized clinicians' laboratory handbook in all services areas with updates (check all tests included). • View customer satisfaction survey report and implementation of identified gaps		

		• View presence of suggestion box to collect customers suggestions that are analyzed regularly • View documented and updated post of available/discontinue test menu with current price implementation practice • TAT to customers. (check TAT monitoring systems) • Confirm the laboratory staffs communicated the available tests to their clients with advisory service • Advisory services for HWs recorded, panic results identified and communicated with HWs to urgent actions • Check what actions taken on essential Lab. tests unavailability (*Laboratory KPI*) by hospital		
4.	The hospital laboratory has and implements a proper management system for its equipment that includes the calibration, maintenance and inventory to ensure the provision of accurate, reliable and timely test results.	• Check laboratory M/Es inventory list updated Lab. department conduct preventive and corrective maintenance for all M/Es as per manufacturer recommendation • Check updated SOPs availability(Operational, Preventive maintenance) job aids, forms,… for each M/Es at each department • Obtain evidence on equipment management system include ways of participation on consultation, selection, specification, installation, calibration with verification plan and performance, maintenance, retiring and disposal		
5.	The hospital has a laboratory supplies management system.	• Confirm the laboratory have functional inventory system for supplies' management • View laboratory has mini store for lab supplies and reagents that should be clean, safe and well ventilated with regular room temperature monitoring • View Bin cards are used to manage laboratory supplies and reagents (check 5 randomly selected bin to update) • View IPLS timely stock status reports and distributions system by service areas and departments		
6.	The hospital laboratory shall implement a process control system that monitors the processes from pre analytical to post analytical phases of testing, including an established internal quality control	**Pre-analytical :** • View well established and isolated sample collection area. • View sample collection manual ready for use in work place. **Analytical phase:**		

	(IQC) and participates in external quality assurance (EQA).	• Obtain records of valid IQC for all tests in regular manner • Confirm whether the laboratory participates in any recognized EQA (PT scheme) or intra laboratory evaluation and scored ≥80% for tests included in that scheme. • Check IQC and EQA out comes evaluated regularly with Lab. staffs and SMT with actions for gaps • Lab. staffs forum with clinical staffs at least quarterly to improve services and Pt, care **Post-Analytical :** • Confirm a system to review results before release independent of testing personnel • View a TAT established for every test and evaluated regularly		
7.	The hospital laboratory has established incident handling and reporting system which includes errors or near errors (near misses).	• View records of occurrences or incidences • View deviations identified and actions taken for improvement and prevent recurrence		
8.	The hospital has established laboratory management information system.	• View written procedure for the laboratory information management system (check for staff awareness with practice) • Confirm the system prevents patient data loss or proves confidentiality, accessibility, accuracy, timeliness, security, and privacy of patient information.		
9.	The hospital laboratory should be designed and organized at least for bio safety level 2 or above and work environment is clean and well maintained at all times.	• View if The hospital laboratory have enough working space • Ensure a laboratory safety program is in place and performed accordingly make sure availability of safety equipment and supplies (first aid kit, spill kit, fire extinguisher, and emergency shower, eye wash, PPE etc) • Interview selected lab staff in order to check relevant safety awareness among staff • Observe for restricted access when work is in progress • Work stations ,floor and walls are easily cleanable,	•	
10.	The laboratory shall design a backup laboratory service through availing back laboratory equipment or and through backup laboratory facility.	• Confirm if a system designed for back-up laboratory service(*M/E, electric Power, supplies)* • View developed and signed MOU by all responsible bodies • View lists of facilities for backup laboratory services for :		

		✓ Actual performances to reduce service delay ✓ Collaborative review of services by the backup facility and ✓ Actions taken to improve • View back-up (water, equipment, electric power, supply) made ready by the hospital		
11.	The hospital laboratory has appropriate storage and stock management systems for blood and blood products received from blood banks.	• View the mini blood bank • Obtain list of transfusion committee members and focal person with their official letters • Obtain singed MoU b/n hospital and nearby Blood Bank • Obtain equipment inventory list and check their functionality status for mini blood bank • View documents and records for blood received ,blood issued and compatibility test • Check committee performance as per the plan and SOP ➢ Clubs established, Campaign conducted,…..		
12.	The HTC in collaboration with respective regional blood back service shall have mobilization of blood donation strategy through community awareness programs.	• Obtain number of awareness creation program in the year • View the list of identified potential blood donors by HTC • Identify notification letter written to blood bank to conduct blood donation campaign • Compare ratio of ***collected*** units of blood ***:*** blood ***received*** from Blood Bank in the last year (the ratio should at least > = 1 : 1)		

13.	The hospital laboratory blood bank service shall have appropriate cold chain system for blood and blood products received from blood bank service until used by prescribers.	• View SOP for cold chain management system • Randomly check Temperature control chart in the last quarter and done every 6 hr • Check regular audits (blood utilization, cold chain Mx) and gaps with actions toward improvement by HTC and SMT • Check the following equipment a. Blood bank refrigerator 2-6oc b. Blood bank deep freezer <-18oC (*optional for primary hospitals)* c. Platelet Agitator 20-24Oc (*optional for primary hospitals)* d. Bench top centrifuge e. Blood group or Cross match plate f. Blood group reagents (Anti-A,B and Anti-D g. Anti-human globulin antisera (*optional for primary hospitals*) h. Biohazard bag i. Blood warmer j. Water bath		
14.	The hospital laboratory blood bank service shall report blood administration and patient safety information to respective regional blood banks.	• View blood transfusion committee performance evaluations and reports address patient safety • Check blood request forms complete to ensure safety • Check whether the transfusion committee evaluate performances and take actions for identified gaps to ward safety • Check all documents are controlled		
		TOTAL	___	___
Comments:				

CHA PTER 10. PHARMACY SERVICES MANAGEMENT

KEY Points:- *Pharmacy service is the last and critical step for clients' services in hospitals through appropriate selection, quantification, procurement and rational use of pharmaceuticals that is designed to assure that quality and safety is maintained at all stages of services.*

S. N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital provides quality pharmaceutical products and effective services in its outpatient, inpatient, and emergency pharmacy service units.	• Check department and individuals' customized JD, plan with implementation • Presence of separate 24 hr outpatient, inpatient, emergency pharmacy service • Drug supply management; DSM, Drug information and Compounding pharmacy service provision units. • Presence of separate store for medicines and other supplies and reagents. • Check availability of prescribed medicines (pharmacy KPI) and actions taken by the DTC and Management		
2.	The hospital has a functional Drug and Therapeutics Committee (DTC) that develops and implements interventions promoting the rational and cost-effective use of medicines.	• Presence of DTC annual plan and implementations for the fiscal year • Presence of terms of reference (TOR) and adherence • Presence of official letter of assignment for members • Presence of at least 6 signed regular meeting minutes in the last 12 months as per the TOR • Presence of regular performance report of DTC activities of the last fiscal year to relevant bodies		
3.	The hospital has a Medicines Formulary listing all pharmaceuticals prioritized by VEN that can be used in the facility. The Formulary is utilized and updated annually.	• Availability of annually updated pharmaceutical list or formulary • The list is prioritized by VEN • Check Consultancy/expertize involvement to update and prepare the list • Prepare STG and adherence monitoring by DTC and department at least every 5 years(***drug formulary &/or annual drug list for primary hospitals***)		

4.	The hospital ensures execution of good dispensing practices at all dispensing outlets.	• Dispensing area workflow organized as: Evaluation & Billing ➔Payment//Processing ➔Counseling • Presence of waiting area with seats in OPD pharmacies • Presence of signed prescriptions by evaluator and counselor (hint: see randomly selected 10 prescriptions) • Presence of records for identified DTPs(OPD,IPD,ER) and measures taken for identified gaps • Presence of report on patient knowledge on correct dosage and satisfaction with actions taken for gaps identified		
5.	The hospital implements auditable, transparent and accountable pharmaceutical transactions and services (APTS).	• Presence of properly recorded and filed prescriptions, sales tickets and registers at dispensaries • Adequate human resource is deployed in each pharmacy services units (hint: based on workload analysis: number of prescriptions and bed size) • Pharmacy premises are arranged so as to keep patient safety and privacy(for patients need special counseling) • Implementation of coding to uniquely identify medicines (service areas, stores) • Bin ownership and updating is implemented • Presence of regular monthly reports for products, finance and services which is evaluated by DTC and SMT with corrective actions • Presence of audit report (internal) with corrective actions • Wastage rate in monetary value is <2% • Presence of annual report on ABC and VEN analyses		
6.	The hospital provides clinical pharmacy services at inpatient, outpatient and emergency departments.	• Completed patient medication profile form, pharmaceutical care progress recording form and medication reconciliation forms are part of the patient chart (hint: see randomly selected 5 patient charts at inpatient ward) • Check Medication reconciliation records, identified gaps and actions taken • Ward pharmacy available at least in major wards and functions for 24 hrs. • Unit dose dispensing is implemented at ward pharmacies (medicines are dispensed only for 24 hrs.) • Regular participation of pharmacists in ward rounds, death audits and seminars (check with evidences)		

7.	The hospital provides drug information services to health care providers, patients and the public.	• Presence of properly filled query receiving and equivalent responses/actions to clients staffs, general community • Presence of recently prepared sample drug alert/newsletter, therapy update, drug monograph. • Presence of regular updates on stock availability to the hospital community (ask health care team or see records) • Presence of medicine use education for patients (check service areas with evidences) • Well-designed DIC having internet access and all necessary supplies for clients and staffs (***DIS with at least internet access for primary hospitals***) • Has started providing poison information with documented evidences • Presence of survey report on patient satisfaction of overall pharmacy services		
8.	The hospital has a functional compounding service.	• Separate premises for compounding service • Availability of equipment, materials and chemicals • Availability of SOP for all compounding procedures • Recorded documents for all compounded items with revenue generation		
9.	The hospital has efficient and effective pharmaceutical logistics management system that reduces the frequency of stock-outs, wastage, over supply and drug expiry.	• Presence of updated procurement policy • Presence of annual pharmaceutical quantification and supply plan approved/agreed by the team and then by SMT • Report that shows percentage of procured items from the hospital request list. • Presence of updated bin card (check bin cards randomly with in mini stores and IPLS of service areas with main stores) • Good storage practice is being followed (see annex) • Check actions taken to sustainable availability of drugs and supplies		
10.	The hospital has appropriate ***both*** paper and computer-based inventory management system.	• Presence of properly recorded of ***both*** paper based and electronic inventory management tool • Presence of regular physical inventory report of dispensaries for main stores		

		• Presence of stock status analysis report, identified gaps and actions taken		
11.	The hospital has an established system for regular monitoring medication use and safety.	• Confirm List of identified susceptible individuals known by the staffs and monitoring ADRs with actions based on reports • Presence of semi-annual prescription monitoring report and actions • Presence of annual DUE Report and actions • Presence of ADE report and actions • Presence of WHO drug use indicator study report and actions • Presence of update on (high alert medications, error prone abbreviations, look-alike and sound alike medication list …)		
12.	The hospital conducts continuous segregation, documentation and safe disposal of pharmaceutical wastes	• Presence of guide line, SOP for disposal for the hospital products • Presence of list of disposed products with description • Expired medicines are separately segregated • Presence of certificate for disposed medicines (minutes during disposal)		
		TOTAL	___	_
	Comments:			

CHAPTER 11. RADIOLOGICAL AND IMAGING SERVICES MANAGEMENT

KEY Points:- ***Radiological services have inherent patient safety and humanity of care issues related to the exposure of radiation, sedation, anesthesia, magnetic field, patient privacy and confidentiality to improve the quality of service delivery and patient satisfaction, minimize patient risk and protect patient privacy.***

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has a separate well designed and equipped radiology unit and qualified personnel that oversees radiological and imaging services.	**Confirm that:** • Organogram, customized JD of the unit and individual staffs • Radiology and imaging services provided 24 hrs • The head is working as a member of at least hospital medical equipment committee • The unit has strategic and annual plan supported by budgets approved by SMT • Check plan implementations according to TOR, identified gaps and actions taken		
2.	The radiology unit has all the necessary layout and infrastructure, personnel and equipment as per FMHACA and ERPA standards.	**Confirm that:** • Hospital received Yearly ERPA certification • Adequate number and mix of professionals (radiographer technicians, radiographer technologists, radiologists etc are maintained as per FMHACA and / or ERPA standards • Adequate utilities are ensured including 24 hour water and electricity supply, toilets (gender separate for general and above hospitals in the department), telephone line, • Identified gaps by regulatory body and actions taken by the hospital		
3.	All radiological and imaging equipment users are appropriately trained on the operation and maintenance of such equipment with standard operating procedures readily available to the service providers.	**Confirm that:** • SOPs are developed and in use for the regular operation and maintenance of all equipment in the unit • Regular orientation and refreshment training is given for all workers in service areas (on how to operate the equipment) where imaging services given		

		• Department set supervision protocol for peer review based on standards and regular performance review to support professionals towards quality		
4.	The hospital has established procedures for the maintenance, calibration, capability, quality control testing and functionality of all radiological and imaging equipment. (at least annually for M/Es having no specification)	**Confirm that:** • All new equipment undergoes acceptance testing prior to its initial use to ensure the equipment is in good operating condition (See testing guides for major imaging M/Es) • All new Equipment is installed and commissioned in accordance with the manufacturer's specifications (verify with specifications) • There is a schedule for inspection, testing and preventive maintenance for each piece of equipment as guided by the manufacturer's recommendations and that schedule is appropriately implemented (verify with recommendations) • There is a notification and work order system for the repair of medical equipment (check documents of repair for uninterrupted services. • Calibration at least annually for those major equipment in need		
5.	The hospital has and implements written policies, procedures, protocols and guidelines for the delivery of all radiological services, interpretations and timely reporting of results for all patients.	Confirm if SOPs and/ or protocols are developed and implemented for the following activities: • Request reviewing(check for findings difference with standards and discussed with clinicians and actions taken) • Client communication and consenting (check to adherence) • Turnaround time(compare standard with actual TAT) • Set Patient preparation and positioning protocols and adhered • Radiation Safety protocols (check with necessary supplies) • Protocol for Contrast administration with consent and management of reactions, drugs used that all activities are recorded • Management of specific situations (pediatric patients, pregnancy, clients needing sedation, emergency patients and prioritization protocols) • Quality improvement activities (identification of quality gaps, action plan development and implementation)		

6.	The hospital has a paper or computer based system for recording and reporting of all radiological and imaging procedures carried out and for archiving all patients' results that are periodically audited for quality assurance, service improvement and expansion.	Confirm : • Service audits done and actions taken for improvement • Policies and procedures for recording, reporting and data handling including confidentiality. • Check Communication policy of the unit with other clinical departments including consultation services and urgent findings		
		TOTAL	___	_____
	Comments:			

CHAP TER 12. REHABILITATIVE AND PALLIATIVE CARE SERVICES MANAGEMENT

KEY Points:- ***Rehabilitation of people with disabilities is a process aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Whilst, palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering. This is achieved by treating pain and other problems (physical, psychosocial and spiritual).***

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital should have a rehabilitation and palliative care service with necessary equipment, aids and appropriate human resources.	• There is a separate, designated area for rehabilitation and palliative care services (*optional for primary hospitals in which **integrated** onsite service with round & inter department consultation system*) • Plan, TOR, service protocols for individual services • Clear customized departmental and individual JD for both services		
2.	With regard to rehabilitation, the hospital should at least provide a physical therapy/physiotherapy service and if possible, occupational, speech and Prosthetics Orthotic Technology.	• A physiotherapist is available in the hospital • Rehabilitation service has education programs in place for patients • A physiotherapy center is equipped with the minimum equipment required as stated in the guide • See numbers of patients discharged with optimum **independence** and those on ***follow up*** at hospital and other stake holders as per the agreement on the plan		
3.	With regard to palliative care services, the hospital should at least provide good pain and symptom control for both in and out patients.	• Palliative care professional assigned (***optional for primary hospitals and at least any trained health worker assigned***) • Essential palliative care drugs for pain management, are available in the hospital in each service areas • Pain assessment is established as a fifth vital sign for admitted patients in the hospital. • Record base line pain and reevaluate regularly • Check recording and controlling of drugs' consumptions		
4.	The hospital should have a written standard operational procedure and patient record management for all rehabilitative and palliative care services.	• There is written guidelines and SOPs for the assessment, implementation and evaluation of rehabilitation and palliative care services • Check communication guide line among professionals, departments, external stakeholders,		

		• Check the document in folder which contains patient rehabilitation/Palliative care assessment, goals, intervention and evaluated outcomes		
5.	The hospital should establish a mechanism for referral and transfer of rehabilitation and palliative care services through in-patient and outpatient and in the case of palliative care, linkage to services that provide home-based care.	• Check agreed plan with stake holders(inter departments) and its implementation • Check Community partners are identified, agreed on the plan and engaged for actual patient care and support • Protocols related to information sharing communication, consultation and confidentiality are developed and implemented		
		TOTAL	____	_____
	Comments:			

CHAP TER 13. INFECTION PREVENTION AND PATI ENT SAFETY

KEY Points:- ***Ensuring hospital cleanliness and safety is an important determinant of quality of care and patient satisfaction. Creating a clean and safe hospital provides comfortable and safe health care environment for patients, attendants, visitors, staff, students, community, and for the surrounding environment.***

Ensuring infection prevention and control and patient safety with the aim of preventing the transmission of infectious agents is the only way to reduce the occurrence of HAIs, and demonstrate a hospital's commitment to the well-being of patients and staff by minimizing the likelihood of HAIs.

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has strategies and operational plan for IPPS as well as a management system to monitor and evaluate the activities.	• Confirm that CASH/IPPS committee is in place and functional(check updated TOR) • Check the hospital has policies, customized JD for focal person • Check Responsibility of committee, plan, strategy address all areas in the EHSTG • Check mechanisms to monitor supplies procurement & utilization by committee and SMT • Check committee have strategic and operational plan on CASH/IPPS and planned activities are implemented based on the schedule, • Check ***regular monthly*** minutes of the committee that is in line with TOR, see identified gaps and ***actions taken*** • Hospital establish systems to ***monitor staffs practice*** toward injection safety and PEP, HCAIs, waste management,…….according to guide line • Check systems for regular refresher and occupational safety training for all staffs(*ask 5 randomly selected employees*) • Check SMT and GB support on CASH/IPPS mainly : ✓ Monitor committee activity and reports ✓ Ensure and monitor supply availability ✓ Encourage staffs and their adherence ✓ Identify priority areas and fill gaps		

		✓ Ensure necessary budget		
2.	Hand hygiene practice is implemented and facilities are provided at all service points at all time	• Check the presence of hand hygiene stations (at minimum with soap , water and functional faucets) at all different service outlets with access to clients and attendants • Check the hospital has continuous water supply at point of use with backup. • Hospital set hand hygiene promotion system: ✓ Hand hygiene posters are posted at a visible location ✓ Celebrate quarterly hand washing days ✓ Recognize best performer individual & departments • Randomly Spot check 5-10 staff from different service points washing hands/interview about ***steps*** and ***critical hand washing times.***		
3.	All the necessary commodities and supplies of IPPS are routinely available and utilized at the designated service areas.	• Check the availability and adequacy of necessary PPE's at all departments • Check PPE provided to Patients and Care givers to CDDs • Check whether proper Utilization of PPEs at different sites • Check mechanisms to control utilization of supplies by SMT • Kitchen PPE full filled and utilized all the time at least: ✓ Face mask ✓ Hair cover ✓ Plastic apron		
4.	The hospital has ensured that safe surgical procedures and practices are in place to minimize risks to clients and providers	• Check the availability and usage of WHO safe surgery checklist for 5-10 clients. • Check the presence of standard surgical antiseptics at all procedure rooms. • Spot check /interview whether safe practices are implemented in the OR including sterilization process		
5.	Safe injection practices are implemented to minimize risk to all surrounding community and management of adverse event related to injection are in place.	**Check** • The presence of SOP at point of use and its adherence • The presence of client education to avoid unnecessary injections		

		• Spot check /interview whether recapping of used syringes is not practiced • Check safety boxes are available at right spot, disposed timely, filled properly including proper incineration		
6.	The hospital practices health care waste management following the national IPPS guidelines	**Observe** • Presence of color coded/Labeled bins • Practice of waste ***segregation***, • Presence of ***well protected*** primary waste storage area • Presence of well-designed functional ***fenced*** incinerator with ash ***pit*** used properly • Presence of ***fenced and ventilated*** placenta pit with tight fitting cover • Check /interview if safety boxes are ***disposed safely*** (*properly quantified, stored and observed during the incineration*). • Proper disposal of liquid wastes ✓ Check presence of septic tank with no leakage of the sewerage system		
7.	The hospital ensures the cleanliness and housekeeping activities	• Cleaning audit should be conducted regularly based on the CASH risk classification schedule using audit tool • Interventions/solutions are provided to solve the gaps based on the audit finding(check monthly report collected from departments/teams • Check/observe the hospital compound cleanliness and • Check /observe service areas are visibly clean and absence of bad odor and well ventilated		
8.	The hospital ensures the availability of adequate and functional toilets, hand washing sinks and showers	**Check** • The number of functional toilets are adequate to clients(***1 toilet for 24 clients estimate)*** • Hand washing facilities are available at all service units • Functional showers available at least in major wards • Proper and separate storage of washed lines with coding		

9.	The hospital ensures Adequate and functional laundry service	• The facility has adequate laundry space • The hospital has at least two washing , one ironing and one drying functional machines(*optional for primary hospitals having at least one each)* • Separate doors for entrance of dirty and exit of clean linen • Separate storage room for clean linen by case teams and type. • Separated cart for transport of clean and soiled linen • Mechanism of cleaning of linens (autoclaving) used to high risk areas like OR, burn units,… • Check adequate detergents and disinfectants with procurement & consumption monitoring specific to laundry department		
10.	All reusable medical equipment are processed according to the national IPPS guidelines	• SOPs for each activities for proper decontamination/sterilization procedures in each departments o Check randomly the major instrument processing steps are known by staffs • Check functionality and how they operate autoclave and dry heat oven for sterilization • Check whether proper high level disinfection procedures are in place • Check whether ***processed items*** are properly labeled and stored • Check available clock and time monitoring on the log sheet • Check heat indicators attached and colored properly		
11.	The hospital has a procedure in place to regulate traffic flow	• Check how the facility handles traffic at procedure rooms as well as in the premises • Mechanism to control crowdedness of waiting areas • The facility has zoning restriction at OR and its practice • Check visiting hours of clients set on the basis of: ✓ Time to rounds ✓ Time to cleaning ✓ Time to meal ✓ No. of care givers allotted to a Pt. and time to stay with patient		
12	The hospital has a monitoring system to ensure safety of food and water served in the premises.	• Check ✓ The cleanliness of the kitchen with CASH audit regularity and actions taken based on results ✓ If kitchen staff/food handlers have periodic medical check up ✓ Interview patients/clients that the food served is in		

		hygienic way ✓ Check if all water sources are lab tested periodically every 3 months and actions taken based on the results ✓ Check hand washing awareness and practice on kitchen staffs		
13	The hospital has a clients' education system for IPPS improvement.	• Check ✓ The presence of client education schedule in which relevant IPPS contents is included both in IPDs and OPDs ✓ Educational materials and supplies related to IPPS ✓ Interview clients/ patients if they get client education for the last three days		
14	The hospital ensures all the post exposure and preventive interventions and procedures are in place in case of occurrence of occupational risks.	• Check if documented reports and actions taken to reduce health facility acquired infections based on observed infection pattern ✓ Post exposure victims are recorded ✓ Availability of PEP and full dose vaccination services for staffs ✓ Confirm event reporting and informed consent are in place		
15	The hospital develops hospital acquired infections tracking and monitoring system	• Check the hospital has a system of tracking of HAI's (Surveillance system) ✓ Check recording of surgical site infection and other HAIs ✓ Designated person/persons is/are in place to conduct regular HAI' surveillance as in CGQM strategies with actions for identified gaps		
		TOTAL	-------	----------
	Comments:			

CHAPTER 14. FEDERAL AND TEACHING HOSPITAL SERVICES MANAGEMENT

KEY Points:- *Teaching processes in hospital setting are critical to providing high-quality care for patients and provide an opportunity for a coordinated plan of care while facilitating full engagement of the patient and/or care givers in making shared decisions about the care.*

Clinical teachers and students need to understand the wider impact of their approaches to ward care, whilst managers bear a responsibility to ensure proper implementations of teaching, patient care and research activities in a way that can improve patient safety, patient experience, team work and efficient use of resources.

S.No	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1	The hospital has established functional management and governance structure that integrates ***patient care, medical education and research.*** ***CED – chief executive director*** ***CCD – chief clinical director*** ***CRD - chief research director*** ***CAD - chief academic director***	• View the organogram of the hospital • View clear customized JD prepared for CED, CRD,CCD,CAD • Check the membership that University GB involved in hospital GB • Check strategic and annual plan coordinate the ***three area of services*** • View executive committee plan , TOR with its implementation • Check engagement of physicians in the implementations of the three Service areas (CRD,CCD, CAD)		
2	The hospital implements an ***orientation*** program for students/interns/residents on hospital policies and procedures prior to clinical attachments.	• View the orientation guidelines • Check orientation guide line addresses all areas of topics (EHSTG) given to all students regularly • Interview five students/interns/residents randomly to check if they have taken the orientation before clinical attachments.		
3.	The hospital has established system to ensure care provided and students' practice maintains patients' confidentiality and privacy at all times.	• View protocols for conducting teaching on patients. o Check orientation address about confidentiality & privacy • Interview 10 patient from different wards on their privacy, confidentiality and ***their involvement*** on the care process. • Observe patient care areas for privacy • CRC implementation progress discussed in each department • Check presence of skill labs and simulation centers for practice		

4.	The hospital has established protocols/policies and procedures for ward rounds and bedside students' teaching to maximize patients' benefit.	• Check for presence of protocol that defines type of rounds (***ward/bedside rounds and Teachings round***) • Interview staff for their knowledge on the protocol and adherence • Check whether student to patient ratio is defined for round • At least departmental daily MDT morning session conducted on critically ill patients • Check Time spent for bedside/teaching round defined & adhered too • On duty physician visit all patients at least during each shift and as necessary for critical patients • Consultant's recommendation on bedside/teaching rounds are implemented and recorded (*if there is*) • Check mechanisms that all findings and recommendations on teaching rounds recorded		
5.	The hospital ensures students/interns/residents' patient care provided is supervised by their respective teachers/hospital based instructors at all times.	• View posted program listing supervisors/teachers for specific unit and for specific date • Beside the students/interns/residents the hospital assigns a staffs (Coordinator) accountable and responsible for all their respective patient care activities at all times. • Check scheduling systems aligned with hospital human resource management system		
6.	The hospital has established guidelines, memoranda of understanding and procedures for affiliation with other teaching institutions, communities and field activities.	• View the guidelines/MoU for affiliation with other hospitals, community, for field activities • Check implementations of the MoU among parties • Check monitoring mechanisms of the hospital management for the implementation of MoU with its stake holders		
		TOTAL	____	_____
	Comments:			

CHAP TER 15. MEDICAL EQUIPMENT MANAGEME NT

KEY Points:-*As healthcare delivery continues to expand and improve, an increasing number of sophisticated medical equipment is introduced, a system capable of supporting and managing these medical technology must be in place to avoid interruption of services. It is very crucial to implement Medical Equipment Management in the hospitals to manage and coordinate the medical equipment management cycle which includes planning and assessment of needs, procurement, training, operation, maintenance, decommissioning and disposal.*

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has in-house Medical Equipment Management ***unit*** with an operational plan, required staff and led by a biomedical personnel.	• Confirm that hospital has Medical equipment management unit • Check unit has developed operational plan • Confirm that the unit is led by a biomedical personnel • Check clear customized department and individual JD prepared		
2.	The Hospital has a Medical Equipment Management Committee composed of doctors, nurses, technicians, pharmacists, and administrative personnel that oversees the medical equipment management program.	• Review medical equipment committee, MEC TOR and ensure the following responsibilities are included: ✓ Verify that MEC membership consists of all parties. ✓ Develop and monitor implementation of medical equipment strategy; ✓ Oversee establishment of medical equipment inventory; develop a ***model medical equipment list;*** ✓ Develop and implement medical equipment policies; ✓ Determine annual budget for medical equipment strategy; ✓ Review incident reports related to medical equipment.		
3.	The hospital has an appropriately equipped medical equipment maintenance workshop.	• Check availability of isolated maintenance workshop • Confirm that the workshop is well equipped with the necessary tools, reference materials, benches, …….		
4.	The Hospital has a paper-based and computer based or automated inventory management system that tracks all equipment and spare parts included in the equipment management program.	• Check M/E inventory committee activity that lead by dep't head • View inventory management system and confirm updated every quarter both in ***paper and computer*** based • Confirm that all medical equipment in the equipment management program is listed in the inventory(***compare with actual MMEL***)		

		• Confirm that the inventory system is used to manage the stock of spare parts with update on bin card		
5.	An Equipment History File is maintained for all medical equipment containing all key documents for the equipment.	• Take a random sample of 10 Equipment History Files and check that each includes ***at least***: ✓ SOP for equipment use, ✓ Inventory data collection form ✓ Risk assessment form.		
6.	The hospital has policies and procedures in place for acquisition of new medical equipment, commissioning, decommissioning and disposal of equipment, the receipt of donations, and outsourcing technical services for medical equipment repair and maintenance.	• Obtain copy of policies and procedures for medical equipment management and verify that they address at least: *acquisition, commissioning, decommissioning, disposal, donations, and outsourcing technical services.*		
7.	All new equipment undergoes acceptance testing prior to its initial use to ensure the equipment is in good operating condition, and are installed and commissioned in accordance with the manufacturer's specifications.	• Take list of equipment purchased in the past year. ✓ Randomly select items and review Equipment Log File is prepared/filled & attached to each . ✓ Confirm that file contains a copy of the Acceptance Test Log Form is filled and attached to each.		
8.	All equipment operators and personnel are trained on proper operation, safety, and maintenance of medical equipment with standard operating procedures readily available to the user.	• Visit a minimum of 3 different departments/case teams ; ✓ Select two items of medical equipment in each department & View SOP for each item. ✓ Interview staff on duty and confirm that each one has received training on the use and maintenance (where relevant) of the equipments. ✓ Check at least refresher training given annually for M/E personnel ✓ Check manuals and SOPs in file in each service areas for M/Ec used as a reference		
9.	There is a schedule for inspection, testing and preventive maintenance for each piece of equipment as guided by the manufacturer's	• Selected 10 Equipment History Files & confirm inspection, testing and PPM has been conducted as described in the schedule (EHSTG).		

	recommendations and that schedule is appropriately implemented.	• Check calibration service done at least for high risk M/Es • Check preventive maintenance, PM done at least every 6 month for M/Es having no manufacturer manual • Check safety inspection done at least for M/Es emits radiation, having dangerous gas/chemical		
10.	There is a notification and work order system for corrective maintenance and calibration of medical equipment based on their level of risk.	• Identify written protocol for medical equipment work orders. • Review at least 5 copies of notification and work order and reports. • Check data for: ✓ No. of work orders received, ✓ No. of work orders completed, ✓ No of incidents related to MEs and actions (all in separate file)		
11	The Hospital ensures Proper disposal of medical equipment according to international, national and regional legislations.	• Check new guide line for pharmaceuticals disposal available in the room • Check M/Es disposed are listed in separate files and rooms • Check disposed M/Es updated/removed from inventory lists		
		TOTAL	____	____

Comments:

CHAPTER 16. FACILITY MANAGEMENT

KEY Points:- *Facility management is all about management of hospital buildings, grounds and utilities essential to ensure that the facility is maintained and in good condition, providing a safe environment for patients, visitors and staff and guaranteeing that clinical services are provided without interruption.*

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1	The hospital complies with relevant laws, regulations, and facility inspection requirements.	Check availability of: • Hospital site Map, • Hospital Map/construction plan/ with update if modifications done, • License (by FMHACA) • Identity letter from relevant bodies for newly established hospitals (***letters for inauguration of the hospital***)		
2	Designated hospital staff members are assigned for facility maintenance and safety functions.	• View organization chart. • Check availability of general service director/coordinator • Check customized departmental and individuals' **JD** which includes functions in facility management and related activities • Confirm on organization chart that the hospital has assigned individuals for the following **service categories each**: masonry, plumbing, electrical installation, landscape and garden, sewerage (***optional for Primary hospitals, but Plumbing and electrical service personnel mandatory***).		
3	The hospital grounds are regularly inspected, maintained to ensure	• Check FMx activities integrated with Annual plan and TOR of IPPS/CASH committee that includes **regular inspection** of hospital compounds to ensure maintenance needs, safety and cleanliness		

	cleanliness of grounds and safety of patients, visitors and staff.	✓ Confirm inspection done as per the schedule and actions taken • Check general service manager working as IPPS/CASH, incidence,…. committee member • View patient and staff areas (garden, waiting areas etc) are tidy, clean and free from hazards (e.g. free of discarded equipment or other materials), • Check ***all walk ways are covered*** and safe for the transport of patients. • Check activities performed & adhered with the plan		
4	Potable water is available 24 hours a day and water sources regularly tested to meet essential patient care and safety to the hospital community(microbiological checks)	Interview Head of Facility management head and observe that; • Alternative source of water exists as a backup (e.g. tank, well). • Obtain documentary evidence that water sources are tested for safety at a minimum every 3 months (see sample submissions) • Check sample taken from main lines to the hospital entry, main and alternate sources within hospital, different service areas, • Check that 4 reports and their ***corresponding actions taken*** based on the results and recommendations • Check 5 randomly selected service areas for water availability		
	Electrical services are available 24 hours a day through regular or alternate sources to meet essential patient care.	**Interview Head of Facility management:** • Confirm that an alternative power source is available (Generator, solar panels,…). • Confirm that this is sufficient to provide power at least to essential patient areas including wards, OR, emergency room, labor and delivery, laboratory, refrigerator rooms,……		

5		• Check the backup generator is automatic or started within 5 minutes. • Check dedicated assigned personnel to ensure Generator functionality and service continuity with sufficient diesels, battery to start up, and document for regular maintenance) • Check 5 randomly selected areas for functional sockets & lighting		
6	The hospital has a maintenance center with technical personnel, sufficient space and adequate ventilation to conduct maintenance and repair (e.g., electrical, water, sanitation, sewerage and ventilation) and equipment.	**View maintenance center:** • Check availability of necessary PPEs for personnel • Confirm that this has adequate space and is not crowded. • Confirm that the general maintenance workshop separated from the medical equipment workshop • Confirm that there are hand-washing facilities, facilities for cleaning and **disinfection equipment**, a storage area, SOPs and necessary ***reference*** materials • Check staff skill mix (*see standard 16 : 2 above*) available on work • Check ventilation and lighting of the room		
7	The maintenance center has appropriate tools and testing equipment to perform repairs, as well as procedures to ensure the routine calibration of the testing equipment is performed as required.	**Interview Head of Maintenance Department:** • Stock of sufficient maintenance tools are available for all functions and that routine calibration/testing is performed as required (test for circuits, switch leak, power,…) • Check availability of spare parts and spare inventory (paper and/or computer based), • Check Backup supplies' with stock management for electric systems, masonry, buildings (cement, paint, metal, wood, glass, …….)		

8	The hospital conducts regular preventive maintenance for all facilities and operating systems (e.g., electrical, water, sanitation, sewerage and ventilation) to ensure patient and staff safety and comfort.	**Interview Head of Maintenance Department and** • Confirm that regular preventive maintenance is conducted. • Confirm that maintenance logs exist for as a minimum: electrical systems, water and sewerage. • View schedule of service areas and documentations for preventive maintenance • Check 5 randomly selected service areas in the previous month conducted as per the schedule		
9	There is a notification and work order system for facility and operating system (e.g., electrical, water, sanitation, sewerage and ventilation) repairs.	**Interview Head of Maintenance Department:** • Confirm that a notification and work order system exists. • Check data for; ✓ No of work orders received ✓ No of completed work orders/actions taken ✓ No of incidents reported and equivalent actions taken (in separate file) • View at least 5 recent work order requests then check equivalent reports on corrective maintenance		
10	The hospital has a transport policy for the use of and access to hospital vehicles.	**View transport policy:** • Check policy includes all areas of concern in EHSTG • Check vehicle service conducted according to the manufacture recommendation • View logs of two randomly selected hospital vehicles and confirm that vehicle utilization complies with transport policy		

		• Interview and check relevant staff (in the general service) adherence to the policy • Check whether measures taken by regulatory bodies on drivers due to violation of the transport policy prepared by the hospital		
11	The hospital has a policy addressing access to the hospital premises.	**View policy:** • Check policy includes (Visiting hour, traffic control, …..) and fixed visit hrs posted at gate, wards with ***its implementation*** • Visit wards and confirm that all attendants are wearing appropriate ID badges (*showing Wards and Bed No*.) • Observe all staffs, clients and vehicles searched/checked on **entry and exit** at hospital check point • Check security training conducted at least annually and to new hire • Check prohibition policy and handover of weapons/sharps by the security department • Check hospital prepare separate vehicle entrance and walking entrance		
12	The hospital has a fire safety ***plan*** that addresses both the prevention and response to fires.	• View fire safety plan that includes fire and evacuation drilling at least biannually to the staffs(*addressing topics in the guide line*) o Obtain documented evidence of most recent Fire Drill (*saved Video, attendances, documents)* • Check water hydrant hoses exist within the facility at least at potential fire points(*optional for primary hospitals*) • Check Fire safety inspection done by authorized body (***optional for*** PH)		

		• Check fire extinguishers filled and updated properly (*as per production & manufacturer recommendation)* • See SOPs for Extinguishers utilization with possible contact address of all stake holders (Police department, electric & water authority, Red – cross society…)		
13	The hospital has a ***plan*** for responding to likely incidences in the hospital or natural and other disasters.	• Check major incidence plan, MIP prepared and approved by SMT and distributed at least to each service areas as reference • View safety and response plan for ***safety*** of all possible incidences are addressed (fire, buildings, sewerages, water sources, Epidemics, ..etc) • Check Roles and Responsibility of staffs and external stake holders addressed in the MIP in response to disaster management • Check implementation of the plan with incidence officer and General service/Facility Management head • Check availability of alarm/command post and Check staff responses **on alarming** • Check disposal manual available for management of hazardous materials in the hospital (*Laboratory, Pharmacy, main Stores*) • Check Hospital set biogas production system using hospital wastes to minimize sewage and get energy power		
14	Staff members are trained and knowledgeable about their roles in the plans for fire safety, security, hazardous materials, and emergencies.	• Check training conducted annually and address: ✓ Operation of firefighting equipment ✓ Evacuation and practices ✓ Responsibility/task sharing/ of each staffs		

		• Confirm that each one knows what action to take and their individual responsibility in the event of a fire and use of extinguisher(*5 staffs*), security threat or other emergency		
		TOTAL		

Comments:

CHAP TER 17. HUMAN RESOURCE MANAGEMENT

KEY Points:- *The most important asset of a hospital is the people who work in it. Every employee starting from the first encounter (Gate) is responsible for and have valuable contribution in carrying out the hospital's duty to care for patients giving priority that the facility attracts, develops, retains and motivates qualified employees to maximize performance of their Facility.*

Any disciplinary action should not come as a surprise to the employee!! *(Any concerns with an employee's performance or behaviour should be addressed at an early stage).*

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has a Human Resources Management Directorate/Department/ Support Process staffed by individuals who possess management knowledge, skills and experience	• Check department and individual customized JD developed(***address EHSTG***) • Confirm that all human resource, **HR** personnel trained at least on **basic** HR management skills (check certificate) • Check onsite capacity building program to HR personnel • Check plan, TOR,…. for implementations, • Check actions taken for identified gaps regarding human resource management with stake holders		
2.	The Human Resources Directorate/Department/ Support Process maintains a personnel file for each and every hospital employee.	Confirm that the hospital has personnel files for all grades of employees: • Check the list equivalent with recent HRIS reports • Observe for individual folders kept in the file cabinets by department/profession using appropriate folder Take a random sample of 5 personnel files from different case teams/departments & disciplines and ensure that they contain at a minimum: • Employee JD ***customized*** to hospital needs and updated to ***current position/staffs rotations***/ ,		

		• 6 month individual BSC performance evaluation ***summary and equivalent individual plans at departments*** • Check JD orientation given during rotation (interview staffs who undergo rotation • Check personnel files contain registration numbers of professionals, pension number,… • Check transfer letters showing experience of employee(training taken, TOTs taken, areas of experiences,….) only for those transferred in to the hospital		
3.	The hospital establishes and institutionalizes Human Resources Information Management Systems (HRIS) that enhance the HR management functions.	**Confirm implementation of HRIS and Updated:** • Check total number of staffs list with HRIS reports • Take 3 personnel files **<u>each</u>** from those promoted, separated from, recruited to and check necessary information are up-to-date • Check personal information fulfilled in HRIS (*including photo,……)*		
4.	The Human Resource Head is a member of the hospital Senior Management Team.	➢ Check his/her member ship in Senior Management Team ➢ Human resource management head play leading role to improve staffs' inter relationship & with the management o Check by randomly select 5 staffs ➢ Check he/she ensure good grievance management **(*transparency policy, good employee communication with prompt response, confidentiality,…..*)** ➢ Check he/she ensure staffs training on need assessment at least per year on different topics, regular HR forum with staffs,……		

5.	The hospital has a human resource development plan that addresses staff numbers, skill mix and staff training and development.	Review a copy of the annual human resource development plan/ HRDP based on need assessment by HR department: • Check Plan address skill mix for short term trainings(offsite and onsite), long term trainings • Ensure that the plan by HR department addresses staff numbers, necessary budget and training schedule on the basis of need assessment with departments • Check the plan approved by GB and SMT • Check whether the plan implemented, evaluated or not		
6.	Each employee's responsibilities are defined in a current job description, which has been signed by the employee and filed in the personnel file	✓ Check hospital implement JD adaptation and customization system in line with hospitals' need for individuals, teams/departments/ even during transfer, assign new positions/service areas ✓ Confirm 5 randomly selected files contain a signed employee JD that; o Includes all roles and responsibilities (include JD for the position/profession and new initiatives based on ***area of current assignment*** including HDA) o New JD given for staffs undergo rotation/ new position		
7.	The hospital has policies and procedures for recruitment and hiring of staff.	✓ Check new hire orientation manual prepared ✓ Check recruitment procedures to ensure qualified personnel for the position ✓ Check there is mechanisms to introduce new hires (induction orientation) ✓ HR audit addressing all in EHSTG should done at least annually		

8.	The Human Resource Directorate/Department/ Support Process provides services to employees to ensure satisfactory productivity, motivation, and morale as evidenced by effective policies and procedures for personnel retention, compensation and benefits, and employee recognition.	Identify written policies for satisfaction packages, motivating & benefits of staffs • Check procedures to ensure transparency on policies and ***practices*** • Check hospital OHS officer relation with HR to ensure safety of staffs, compensations & benefits • Identify documented policies and plans that support employee motivation and retention with the exception of Civil Service benefit packages o Check plan implementation and evaluation of satisfaction package set by hospital		
9.	Human Resource department prepare an Employee Hand Book that contains policies and procedures in a hand which is distributed at least on department level and updated at a minimum, every 5 years.	• Check that it contains Hospital personnel policies and procedures such as working hours, leave, benefits. • Check that it has been updated and is current (within 5yr renewal window). • Verify that it has been disseminated among staff (at least by department) • Check minutes in randomly selected 3 service areas that the department staffs discussed on it • Interviewing a random sample of 5 staff from case teams and check their knowledge ✓ Check orientation to whole staffs given at hospital level at least annually		
10.	The hospital has a Code of Conduct and Professional Ethics that is known, and adhered to, by staff.	Obtain a copy of the hospital's code of conduct and professional ethics addressing all areas in EHSTG and monitor their adherence of staffs • Interview 5 random staff members from different Case Teams and ask if they are familiar with the Code of Conduct(general understanding, principles),and the areas covered in the Code of Conduct including EHSTG		

11.	The hospital has a performance management process and reward policies in which all employees are formally evaluated at least semiannual, higher performers are recognized and rewarded, and action plans for poor performance improvement	• Check HR department in collaboration with GB and SMT implement all the three PMx components with set policies (EHSTG) • Confirm that the 5 randomly sampled files contain signed performance evaluation conducted **twice** within the past year (with the exception of new employees) & check their equivalent agreed BSC plan found at their department. • Hospital evaluate departments and select best performers rated and posted (possibly by photo and name) on quarterly basis after result approval by SMT & GB ('*employee of the month'* program with transparent selection criteria) • Recognition program of employees and units at least annually based on methods of recognition listed in their plan		
12.	The hospital regularly conducts a staff job satisfaction survey and exit interview to assess staff opinions about their workplace at least ***biannually***	• Confirm that survey conducted twice within last 12 months • Check survey conducted as per the protocol (***whether sufficient no. of staffs participated, actions taken based on results)*** • Results discussed presented to staffs, SMT, GB o Check minutes, action plans identified gaps implemented in a timely manner by SMT and GB • View the documented exit interview and summary report and ***corrective actions*** on recommendations(***if there is***)		
13.	The hospital ensures employees wear ID badges and appropriate uniforms at all times.	• Check dressing code policy of the hospital based on national/regional legislation • Check individual staffs on the course of the assessment wearing an ID badge and uniform all the time		

		• Check minutes and attendances on staff orientation program on uniform coding of hospital employees by HR department • Check posts of dressing code in service areas to clear understanding both for staffs and clients		
14.	The hospital has occupational health and safety policies and procedures to identify and address health and safety risks to staff.	• Obtain a copy of occupational health and safety policies and procedures as per regulations (Civil service and EHSTG) • Check areas of risks identified and risk assessment done in the hospital • Check HR integration with committees (at least with Quality , IPPS,…) of the hospital on safety of staffs • Check all appropriate staffs vaccinated for HBV(interview 5 randomly selected new hires among staffs from risk areas)		
		TOTAL	__	____

Comments:

CHAPTER 18. HEALTH FINANCING AND ASSET MANAGEMENT

KEY Points:- ***Health financing refers to the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people. Financing is much more than simply generating funds and it is not the amount of health spending, but the efficiency with which those funds are used, that matters most to ensure that those resources are put to good use, deliver "value for money," and achieve the intended outcomes or impact.***

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has established finance, procurement and asset management structure, personnel per positions and an operational plan , approved by the Senior Management Team and GB :	• Check customized departmental and individual JD developed • Check the hospital has both operational and strategic plan with implementation, gaps identification and actions taken • Check the process of submitting ***procurement needs*** and approved procurement plan • The responsible body/person for approval of procurement requests • There is approved means of procurement for the hospital • Approved Responsible person(s) for procurement activities • Check plan includes forecast of expected ***retained revenues*** and ***possible sources***. • Check the activities planned are implemented based on the schedule and monthly and quarterly report submitted to relevant bodies		
2	Bilingual service fee schedule posters are displayed beside main service areas(languages should be of majority speakers in the area)	• Visit departments and confirm that bilingual service fee schedule posters are clearly displayed at all receptions, all waiting areas and all cash points. • Confirm that the poster shows fees and advises that patients should obtain and to keep receipts for all payments. • Check 3 clients from service areas randomly for receipts, understanding of language		

3.	The hospital provides exempted services in accordance with the relevant Federal/Regional Legislation and displays a list of exempted services at appropriate locations through the hospital for the information of patients, staff and the public.	• Obtain relevant Federal/Regional Health Care Finance Reform Directive. • Obtain list of all exempted services that are provided by the hospital. • Confirm that the list displayed at main service areas in the hospital and matches the list in the federal/Regional Directive. • Check randomly exempted services are provided free of charg		
4.	The hospital provides all services indicated in health insurance benefit package in accordance with the agreement and should be displayed at main service areas in the hospital for information for the patients, staff and the public (***N/A for non CBHI HFs***	• Get the contractual document for CBHI • Take sample patient records and visit each department and confirm whether all the services indicated in the benefit package are properly provided to beneficiaries (***unmet if a single service missed for the CBHI benefit packages from insourcing contracts***		
5.	The hospital submits timely payment requests/claims /reimbursements for services to the Health Insurance Agency and ***fee waiver*** beneficiaries in accordance with established standards and formats.	• Confirm that claim documents are properly prepared both in hard and soft copy and ***timely submitted to beneficiaries as per the agreed schedule*** • Check all parties took agreement with time of summiting service reports by the hospital • Confirm that a necessary registries and formats are prepared (computer and paper based)		
6.	The hospital keeps records of services provided to eligible health insurance, fee waiver and exempted service beneficiaries and related financial information as appropriate and reported to the relevant body (see bases on applicable service packages)	• Confirm that financial records of health insurance, fee waiver and exempted service beneficiaries properly kept and documented both in soft and hard copy • Take list of samples beneficiaries and confirm that whether the beneficiaries are included/recorded properly in the list of health insurance or fee waiver or exempted service beneficiaries • Check all payments from all parties(***both CBHI and fee waivers***) in the last quarter collected on time according to time of their agreement		
7.	The hospital ensures a private wing service is established in accordance with the required federal /regional directives and approved by the Hospital Governing Board. (***N/A - for those approve non applicability of private wing***	• Establishment of private wing services was approved by the SMT and GB • The private wing services fees are approved by the SMT and GB • Check for mechanisms of reimbursing supplies of the hospitals that are utilized for private wing services		

	based on their project plan by the SMT and GB on annual basis)	• Check all necessary documents (private wing guide line, operational plan, minutes for approval, • Check service equivalency monitoring system with normal working hours (time of service start, service volume not exceed 60%,…..)		
8.	In a hospital where services are outsourced, procedures are in place to monitor the contract and services provided and contractual agreements comply with relevant government directives. (***N/A – if studied and approved by SMT and GB as non - applicable on Biannual basis***)	• Confirm that an assessment of the feasibility of outsourcing services has been undertaken and project plan developed and approved by SMT and GB • Confirm Contractual agreement procedures have been developed that define the outsourcing process and what services are outsourced • View the most recent performance reports of outsourced service • Check minutes for approval • Check monitoring and approval of services before payments		
9.	The hospital establishes mechanisms that fiscal information is channeled through various medium of communication to the community.	• Obtain Annual budget communicated to the public through appropriate means to ensure transparency • Confirm that In-year budget execution reports (the reports are routinely made available to the public through appropriate means within one month of their completion). • External audit reports (all reports on consolidated operations are made available to the public through appropriate means within six months of completed audit) • Annual finance reports displayed for the community		
10.	The hospital stock management ranging from identifying the need for a property to materials and supplies in order to receive, use and dispose complies with the relevant guidelines and disaggregated by each department.	• View annual procurement plan that is approved by the hospital SMT and GB. • View use of transparent competitive procurement methods(Bid documents) • Check means of controlling mechanisms to ensure quality of procured items whether as per the specification of the requests • View reports and confirm all assets are included in annual inventory (properties, medication and supplies, disposal documents, APTS reports and minutes. ……) • There is effective internal controls to reduce the risk of mistakes and fraud to safeguard assets with actions on findings.(stock/Bin cards, computer based registrations) • Verify Degree of compliance with rules for processing, recording, use and disposal of stokes with relevant guidelines (disposal manual, property management manual,…..)		

11.	The Hospital accounting system should produce and access periodic reports to the relevant bodies at all levels.	• View last 3 month financial report and confirm that each provides details of credit granted, credit repaid and balance outstanding • Routine data collection or accounting systems provide reliable information on all types of resources received in cash and in-kind by departments across the hospital. (***The information is compiled into reports at least quarterly both computer and paper based***) • Verify that regular, timely, and accurate information on actual budget performance is produced at least quarterly and used for decision by SMT and GB (***see evaluation minutes and feedbacks by SMT and GB).***		
12.	Internal audit on quarterly basis and external audit at least once in a year conducted and reports are reviewed by the senior management and Governing Board.	• Internal audit is operational for the hospital and generally meets professional standards and should focused on systemic issues. • Internal audit reports regularly on quarterly basis and are distributed to the SMT, GB, and relevant bodies. • See evaluation minutes, direction on actions to be taken on findings which has been given to FINANCE department as feed backs regularly. • Check external audits, recommendations and actions based on findings at least once every two years.(see actions by SMT and GB based on recommendations)		
		TOTAL	–	—
	Comments:			

CHAPTER 19: CLNICAL GOVERNANCE and QALITY IMPROVEMENT

KEY Points:- ***Clinical Governance is the system through which hospitals are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence can flourish. It organizes multidisciplinary teams and the involvement of patients.***

Clinical leadership is critical to the success of any hospital that the board & the management together leads the hospital strategy for clinical governance and quality improvement. The CG&QIU team will be available for staff to share experiences, ask questions and offer solutions to colleagues on their day to day quality improvement activity -> 'Quality is a moving target and continuous improvement'.

Clinical governance and quality management requires health professionals having up-to-date knowledge (as 'Quality of today may not of tomorrow') of the most effective diagnostic tests, treatments and procedures. Therefore all staff in a facility have a responsibility to ensure that all interactions with patients and carers are undertaken with respect for the individuals -> 'Quality is everybody's business!!'.

S.N	OPERATIONAL STANDARDS	VERIFICATION CRITERIS	Met	UnMet
1	The hospital has a Clinical Governance and Quality Improvement Unit that is led by at least MPH/MSc or General Practitioner.	• The hospital quality unit lead by at least MPH/MSC or General practitioner: • Confirm if there is letter of assignment with customized departmental and individual JD developed and signed • Check QU head is member of hospital SMT • Check department QI team lead by senior physicians (*GP if no senior for primary hospitals*) • Check Quality Committee members' list include physicians from all department • Check plan and TOR prepared, agreed by all members and well adhered • Check QC meeting minutes (Regularity, attendance of members,…) as per TOR • Check the structure for implementation, monitoring and evaluation of QI projects by QU, GB, SMT and departments that all lead by the QU.		
2	The hospital should develop a clinical governance and quality improvement strategy and an operation plan that addresses the key components of quality.	• View Clinical Governance and Quality Improvement strategy approved by GB & SMT and ensure that the **strategy includes**: ✓ Safety and risk management ✓ Clinical effectiveness ✓ Clinical Audit ✓ Professional competence using different methods ✓ Patient focused care ✓ Patient and public involvement		

		✓ Benchmarking ✓ Check if there is annual plan • Confirm that reports regularly received and evaluated by SMT and GB taking 'No. of graduated QI projects' as a major indicator		
3	Procedures are established to monitor clinical practices and standards through services' specific process and outcome measures to enable the hospital to address any problems identified	• Check list of clinical outcome measures developed and monitored regularly. o See the most recent results of at least 3 clinical outcome measures and appropriate action based on results to provide safe and quality service. o Confirm with 5 selected staff from clinical service areas whether they are aware of selected clinical outcome measures		
4	The hospital implements a regular clinical audit program in each service area. Such program encourages the participation of all clinical staff and includes the implementation of a quality improvement plan derived from audits.	• Check that all relevant clinical service areas are self-audited based on HSTQ • Check the composition of audit team (staff and service users involvement) from audit reports. • Verify audit reports and an improvement plan (QI project) produced for improvement • Check whether *re-audits* are conducted to close gaps identified during previous audits & check if there is an improvement.		
5	Procedures are established to assess and minimize risk arising from the provision and delivery of health care. A system is also in place for reporting and analyzing incidents, errors and near misses	• View regular ***risk assessment-reports*** and actions of inpatient, outpatient, ER case teams, laboratory and other departments at least quarterly • Confirm that the hospital has an Incident Officer who has a job description that outlines his/her duties in relation to incident investigation and management. • View two recent Incident Reports (if any) and confirm that the reported incidents were investigated and any necessary follow up action documented by the Incident Officer. • Confirm that the hospital has a plan to identify, analyze and monitor risks, incidents, errors and near misses with staff involvement from respective service areas		
6	The hospital adopts a statement of patient rights and responsibilities, which is posted in public places in the hospital	• View statement of patient rights and responsibilities. • Visit patient service areas (as a minimum OPD, ER and inpatient wards) and confirm that statement is clearly displayed.		
7	The hospital continuously and systematically reviews and improves all aspects of its activities that directly affect	• Check occupational safety issues lead by QU and work with HR, hospital incidence officer, IPPS focal…… • View strategy in QU that includes identified risks assessed,		

	patient safety and apply best practice in assessing and managing risks to patients, staff and others.			
8	The hospital monitors patients' experiences with care through patient and satisfaction surveys conducted on a quarterly basis.	• View results of last patient satisfaction survey. • Confirm that survey conducted regularly every 3 months. • Check and confirm that actions were taken as a results of patient satisfaction survey score • Check actions taken to patient satisfaction improvement		
9	The hospital implements a strategy for the involvement of patients and the public in service design and delivery including procedures to be followed when engaging with patients and the public	• View minute document of the Hospital's Public Forum • Confirm that public forums or town hall meetings are conducted at least every quarter with saved audio – visual document with date • Check whether the hospital informs the public through o Patient information leaflets o Poster displays in hospital or community o Publications in local press o Presentations at public meetings • Check and confirm suggestion box is used in the hospital and that suggestions are compiled, analyzed and acted up on. • Confirm Community representation on hospital Governing Board • View patient and public involvement strategy of the hospital. • Confirm (by interview with CEO or Chair of QU) that the following activities have been conducted within the previous quarter: o Complaints procedures received versus resolved o Establishment of patient groups & meeting conducted with minute • Check activities to engage marginalized groups of the community		
10	The hospital develops and implements a strategy to provide patient focused care which incorporates, compassion, respect and dignity for patients, effective communication, better hotel services and involvement of patients in the care delivery	• View hospital Compassionate, Respectful and Caring Healthcare Professional Strategy • View and confirm whether the strategy covers issues about respect and dignity, effective communication, better hotel services (housekeeping, nursing care, balanced diet (food) services, laundry services) • Check hospital set follow up system for CRC implementation as individual and team		

		• Randomly ask and confirm patients and care givers in ward if patients concerns are taken into account and they are involved in the care delivery.(10 clients from IPD) • Check CRC audit and actions taken to better performance as department and hospital/QU level		
11	The hospital participates in benchmarking activities to learn from and share good practice with other hospitals.	• Confirm (by interview with CEO or other documented evidence) that hospital participates in benchmarking activities. For example regional hospital meetings; • Check and confirm that the hospital attends EHAQ Cluster meetings • Check and confirm with selected hospital staff that they are well aware of EHAQ Change Package		
		TOTAL	----	----

Comments:

CHAPTER 20: MONITORING AND REORTING

KEY Points:- *Hospital management at all level and Governing Boards are responsible to monitor hospital performance using indicators (HMIS, KPIs, EHSTG,HSTQ & local indicators set by the GB &/or respective regions)to achieve the following objectives:*

- *To ensure that activities are proceeding as planned and on schedule (i.e. to ensure that the annual plan is being implemented) using quality data for decision making,*
- *To maximize the quality, effectiveness and efficiency of services provided by the hospital*
- *To ensure financial viability of the hospital, and*
- *To ensure that the hospital contributes to attainment of national health sector targets and objectives.*

	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Un Met
1	The hospital has an HMIS Monitoring Team (or equivalent) which collaborates with the CG&QIU in reviewing the HMIS and KPI indicators and takes action to address any areas of concern.	• Check department/committee and individual customized JD developed • Confirm that HMIS/KPI Performance Monitoring Team is in place. o View team composition including at least department heads/data owners/QU Head • View plan and TOR of PMT whether adhered to their functions • Check Committee lead/chaired by QU head or CCO • Check PMT follow schedule of evaluation of performance by service areas to be in HMIS/KPIs time frame before reporting to relevant bodies • The hospital set Local indicators in addition to KPIs, HMIS, to be evaluated regularly(check practice from committee members and minutes) • View minutes of last 3 HMIS/KPIs performance monitoring team meetings and confirm that HMIS/KPI indicators are reviewed and ***action taken*** based on findings.		
2	The hospital/PMT conducts a self-assessment of its own performance at a minimum every monthly', using HMIS indicators, KPIs and any additional local indicators determined by hospital management or RHBs	• View last 3 self-assessment meetings (by the PMT) all with ***HMIS time frame*** • Confirm that frequency of meeting was monthly from minutes. • Interview relevant staff whether there is an action and implementation plan based on the self-assessment result.		
3	The hospital submits monthly, quarterly and annual HMIS reports to the relevant higher office within the agreed timelines.	• Check whether the reports are evaluated at each level finally by the hospital SMT and GB before submission to relevant bodies with HMIS time frame		

		• View HMIS/KPI reports for last year and Confirm that monthly, quarterly and annual reports were submitted as per HMIS schedule.		
4	The correspondence between data reported on HMIS forms and data recorded in registers and patient / client records, as measured by Data Quality Assurance (DQA) and Lot Quality Assurance Sample (LQAS) is ≥85%	• View LQAS result on last 3 HMIS/KPI reports. • Confirm LQAS is > 85%. • Confirm LQAS calculation is according to LQAS methodology. • Check whether corrective actions taken based on findings		
5	CEO with the Clinical Governance and Quality Improvement Unit have evaluated the performance indicators for the hospital that are described The CEO and reported by the CEO to the Governing Board as a minimum every quarter.	• View last 3 HMIS and KPI reports submitted to Governing Board on quarterly Basis • Check whether action plan implementation on identified gaps • Check evaluation and reports whether with in HMIS time frame		
6	Indicators included in the hospital performance monitoring system are a combination of national/regional indicators and other local indicators as determined by the Governing Board.	• View list of indicators and confirm that some are national indicators while others are local indicators set by the SMT and GB • Check whether all the selected indicators regularly evaluated and actions taken based on findings • Check regular evaluation of ' No. of graduated QI projects' by GB and SMT		
7	Hospital staff receive orientation on all performance indicators and case teams/departments determine indicators and monitor their own performance using the process improvement model	• Check selected staff about their awareness on KPIs and their involvement in monitoring & evaluation of KPI's in their service areas. (10 relevant staffs from different service areas) • Check availability of data owners from each case team/service area for respective service area KPIs • View reports/minutes of case team whether in line with HMIS time frame /schedule set by the hospital		
		TOTAL	---	-----
	Comments:			

Summary Table of the EHSTG by Chapters

Chapter	***Number of Standards Met***	***% of Standards Met***	*Remarks*
Hospital Leadership, Management and Governance			
Liaison, Referral and Social Services			
Emergency Medical Services Management			
Outpatient Services Management			
Inpatient Services Management			
Medical Records Management			
Nursing and Midwifery Care Services			
Maternal, Neonatal and Child Health Services			
Laboratory Services Management			
Pharmacy Services Management			
Radiological and Imaging Service Management			
Rehabilitative and Palliative Care			
Infection Prevention and Patient Safety			
Federal and Teaching Hospitals Management			
Medical Equipment Management			
Facility Management			
Human Resource Management			
Health Financing and Asset Management			
Clinical Governance and Quality Improvement			
Monitoring and Reporting			
Total 197(*191 for Federal & Teaching Hospitals*) standards			

General comments of the assessor/s (by Team Leader): ----------

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Region:----------

Name of Hospital;----------

Name of hospital CEO/CCO ----------

Signature ----------

Tel. ----------e-mail: ----------

Name of assessors' team leader: ----------

Signature: ----------

Tel : ----------e- mail: ----------

Date of assessment: ----------