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Egyptian Hospital Accreditation Program: Standards

Sixth Edition
May 2005

Order No TK 013

Mission

Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

▲ *Implementation of appropriate health system reform.*

▲ *Generation of new financing for health care, as well as more effective use of existing funds.*

▲ *Design and implementation of health information systems for disease surveillance.*

▲ *Delivery of quality services by health workers.*

▲ *Availability and appropriate use of health commodities.*

May 2005

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Abstract

The Egyptian Ministry of Health and Population (MOHP) with the assistance of the USAID-funded Partnerships for Health Reform Project (1995–2001) successfully developed and implemented an accreditation program for their primary health centers. Building on this experience, the MOHP Quality Improvement Directorate drafted a set of standards for hospital accreditation. The standards then were refined with the collaboration of government/public sector hospitals, university hospitals, teaching hospitals, and private hospitals. The USAID-funded Partners for Health Reform*plus* Project provided technical assistance to this current version of the hospital accreditation standards. The standards are specific for Egypt, in that they comply with Egyptian laws, regulations, and culture, but they also meet the basic intent of international standards.

A total of 716 standards were developed and agreed on, and are categorized into three types: (69) critical standards, (322) core standards, and (325) non-core standards. To become accredited, a hospital must meet all the critical standards and reach a cumulative score of 85 percent on the core standards. The non-core standards constitute a more ambitious target that hospitals are encouraged to work toward; current accreditation requires hospitals to reach a cumulative score of 40 percent on the non-core standards.

The standards are expected to serve as a catalyst for change and improvement in both the culture and practice of health care in Egypt

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Acronyms{tc "Acronyms"}

CPR	Cardiopulmonary resuscitation
CSSD	Central sterilization supply department
CT	Computerized Tomography
EDL	Essential Drug List
H&P	History and physical examination
HVAC	Heating, ventilation, and air conditioning
IBCLCs	International Board Certified Lactation Consultants
ICUs	Intensive care unit
MOHP	Ministry of Health and Population
PHR*plus*	Partners for Health Reform*plus*
QI	Quality improvement
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Foreword

This is the sixth edition of the accreditation standards for Egyptian hospitals. The development of these standards was a collaborative effort of representatives from all health sectors, including the Quality Improvement Directorate of the Ministry of Health and Population (MOHP), university hospitals, teaching hospitals, and private hospitals. The standards are specific to Egypt, but they have been compared to international standards and found to meet the basic intent of all international standards that apply to Egyptian laws, regulations, and culture. It is expected that the standards will be a catalyst for change and improvement in both the culture and practice of health care in Egypt.

The standards are divided into three categories: critical standards (written in bold italics), core standards (written in bold type), and non-core standards (written in plain type). To become accredited, a hospital must meet all the critical standards and reach a cumulative score of 85 percent on the core standards. The non-core standards are a future and even higher target. To become accredited, a hospital must reach a cumulative score of 40 percent on the non-core standards.

Acknowledgments

1. Patient and Family Rights

Introduction

Each patient and his or her family are unique, and the hospital and its staff should strive to understand each individual's needs, beliefs, and rights. Although patients and families may be very trusting of their doctors and the hospital, care outcomes and patient/family satisfaction are improved when patients receive sufficient information to participate in decisions regarding their care, to the extent they wish to participate.

This chapter outlines processes to perform the following:

- Obtain the patient or family's consent for certain types of procedures or treatments

- Ensure that the patient is informed and protected when enrolled in a research project

- Allow the patient or family to make complaints or offer suggestions

- Evaluate patient and family satisfaction

- Identify and protect the patient's rights

PR.1 *The hospital has a specified list of procedures or treatments for which informed consent is required from the patients or other authorized person. The lists includes the following (when applicable to the hospital's services):*

PR.1.1 **Surgery and invasive procedures**

PR.1.2 **Anesthesia/moderate or deep sedation**

PR.1.3 **Use of blood**

PR.1.4 **Research**

PR.1.5 **High-risk procedures or treatments (including but not limited to Electro Convulsive Treatment, radiation therapy, chemotherapy)**

PR.2 **The hospital complies with laws and regulations governing when someone other than the patient can give consent.**

PR.2.1 If consent is given by someone other than the patient, this is documented in the patient's medical record.

PR.3 Patient consent forms are available in all applicable locations at the hospital. The locations include at least the following:

PR.3.1   All nursing inpatient units

PR.3.2   All areas where surgery or invasive procedures are done

PR.3.3   All ambulatory clinics where procedures on the list requiring consent are done

PR.3.4   Radiation therapy

PR.3.5   Outpatient chemotherapy area

PR.3.6   Psychiatry units where electroconvulsive treatment is done

PR.4   **Informed consent is obtained for all relevant processes of care, including research, before performing such procedures or starting the research. Informed consent requires giving patients information about the risks, benefits, and alternatives to the proposed treatment plan. The patient's signature or other documentation of consent is in the patient's medical file.**

PR.5   *The hospital ensures that the Ethics Committee has reviewed and approved all research protocols that involve human subjects as required by law.*

PR.6   There is a process to allow patients to make oral or written complaints or suggestions and the process allows the complaint or suggestion to be anonymous if the patient so wishes.

PR.6.1   Relevant staff members understand this process and can advise patient and family.

PR.7   There is an assigned committee for reviewing and acting on these complaints and suggestions.

PR.7.1   This committee has terms of reference that include the following:

PR.7.2   Reviewing aggregate data relating to complaints to determine if there are any recurring problems

PR.7.3   Taking action to correct any recurring problems

PR.7.4   Reviewing the action taken on individual complaints to determine if it   was appropriate and timely

PR.7.5   Committee minutes demonstrate that the terms of reference were met.

PR.8   **The hospital provides training in patient satisfaction and interpersonal communication for staff.**

PR.8.1   **All medical and nursing staff have been trained.**

PR.8.2   All other staff have been trained.

PR.9   **The hospital has implemented a patient satisfaction questionnaire.**

PR.9.1   An adequate sample size is obtained.

PR.9.2   Aggregate data from these questionnaires are analyzed at least twice every year.

PR.10   *Written policies on patients' rights are available, disseminated, or made visible to patients. Patients' rights include at least the following:*

PR.10.1   Right to reasonable access to care

PR.10.2   Right to care that respects the patient's personal values and beliefs

PR.10.3   Right to be informed and participate in decisions relating to their care

PR.10.4   Right to security, personal privacy, and confidentiality

PR.10.5   Right to have pain adequately treated

PR.10.6   Right to make a complaint or suggestion without fear of retribution

PR.10.7   **Right to know the price of services and procedures**

PR.10.8   **Rights as defined by laws and regulations**

PR.10. 9   **Informed of their rights in a manner they can understand**

PR.11   The hospital has a policy that defines its responsibilities for patient's possessions. The policy defines at least the following:

PR.11.1   When the hospital assumes responsibility for these possessions and how it will protect them

PR.11.2   Information to be given to the patient or family about the hospital's responsibility

PR.12   **Signed patient consent form or documentation of the patient's verbal consent for participation in research is available in the research files.**

PR.12.1   **A copy of the consent form or other documentation of the patient's participation in the research project is in the patient's medical file.**

PR.13   The hospital informs patients and families about its services and how to access those services.

PR.14   The hospital informs patients and families about their rights and responsibilities related to refusing or discontinuing treatment.

PR.14.1   There is a written hospital policy.

PR.15   Social Services Department is directed and staffed by experienced and qualified individuals, as required by the job description.

PR.15.1   The hospital has defined in writing the scope of services to be provided by the Social Services Department and the timeframe in which these services are to be provided.

PR.16   Social services are integrated with services provided by different departments.

PR.17   The Social Services Department is involved in community needs assessment and health education activities.

2. Access and Continuity of Care

Introduction

Hospitals vary in the scope of services they provide and thus the types of patients they may effectively serve. Patients frequently receive care by more than one department and in more than one location. An episode of care must be understood as a continuum from admission to discharge and not a sequence of isolated actions. Therefore, the hospital and its staff must work collaboratively to make this continuum work smoothly.

This chapter defines processes to perform the following:

- ▲ Ensure that the hospital can effectively meet the patient's needs

- ▲ Admit patients

- ▲ Determine the priorities for patients' care

- ▲ Conduct transfers within the hospital

- ▲ Conduct transfers to another hospital

- ▲ Have available the medical record as a communication tool

- ▲ Discharge patients from care

AC.1   **There are policies and procedures to ensure coordination and continuity of care that include at least the following:**

AC.1.1   *Process to screen patients to determine that the hospital can meet their health care needs*

AC.1.2   **Admission of patients, including those from emergency services**

AC.1.3   **Information to be given to the patient at the time of admission**

AC.1.4   **A triage process to determine priority of care in emergency services**

AC.1.5   **A screening process after admission to determine the priority of the patient's medical and nursing care needs**

AC.1.6   **Criteria for admission to specialized units such as intensive care units (ICUs)**

AC.1.7   **Specific criteria for eligibility for enrollment in research projects or protocols**

AC.1.8   **Transfers from one hospital unit to another, including documentation of the process, in the patient's medical file**

AC.1.9   **Transfers from the hospital to another hospital, including monitoring and mode of transportation and requirment to notify the receiving hospital.**

AC.1.10   **There is evidence that appropriate staff, including physicians, have been educated about these policies.**

AC.1.11   **The policies have been implemented and are being followed.**

AC.2   **Diagnostic services and surgical and non-surgical treatment services are available and there are defined timeframes for the availability of these services.**

AC.2.1   The diagnostic and treatment services are appropriate to the types of patients served.

AC.3   **The patient's record must be available to care providers and contain up-to-date information and must be available within one hour.**

AC.4   The hospital has a policy that identifies who may have access to the patient's record to ensure confidentiality of patient information.

AC.4.1   The policy defines the circumstances under which access is granted**.**

AC.5   *The complete patient record containing up to date essential information must be transferred with the patient when being transferred from one unit to another within the hospital.*

AC.5.1   The medical file must document the reason for the transfer.

AC.6   *Patient records must contain a copy of discharge summary. The discharge summary must include the following:*

AC.6.1   **The reason for admission**

AC.6.2   **Significant findings, including investigations**

AC.6.3   **Procedures performed**

AC.6.4   **Any diagnosis made**

AC.6.5   **Medications and/or other treatments**

AC.6.6   **Patient's condition at discharge**

AC.6.7   **Discharge instructions, including medications and follow-up instructions**

AC.6.8   **The name of the physician who discharged the patient.**

AC.7   **A referral sheet containing patient's clinical information is completed and sent with the patient when referred to another facility. A copy is retained in the patient's record. The referral sheet contains at least the following:**

AC.7.1   **Reason for referral/transfer**

AC.7.2   **Significant findings, including investigations**

AC.7.3   **Procedures, medications, and/or other treatments**

AC.7.4   **Patient's condition at time of referral or transfer**

AC.7.5   Name of the facility the patient is being transferred to

AC.7.6   Transportation means and required monitoring

3. Patient Assessment

Introduction

Evaluation of the patient to determine his or her needs and the priority of those needs is the basis on which subsequent care decisions are based. The evaluation may be done by multiple qualified disciplines and the content of the assessment may vary according to the patient's condition or location of care. The evaluation may include relevant diagnostic investigations. The assessment and reassessment is a continuing process throughout the patient's course of care.

This chapter describes the evaluation process, including the following:

- By whom, when, and how evaluations and reevaluations are done

- Diagnostic investigations

General Patient Assessment Standards

PA.1   *All patients have their health care needs evaluated by defined assessment processes.*

PA.2   The hospital has defined who may assess patients**.**

PA.3   **Each discipline has defined the scope and content of assessments, including the timeframe for their completion.**

PA.4   **Each discipline has defined the frequency of reassessment.**

Pain

PA.5   When relevant to their condition, each patient has his or her pain assessed, treated, and reassessed to determine the effectiveness of treatment.

Laboratory

LB.1   *The hospital has written polices and procedures for laboratory services. The policies include at least the following:*

LB.1.1   **Procedure manuals or guidelines for all tests and equipment**

LB.1.2   **Report times for results**

LB.1.3   **Quality control processes**

LB.1.4   **Inspection, maintenance, calibration, and testing of all equipment**

LB.1.5   **Management or reagents, including availability, storage, and testing for accuracy**

LB.1.6   **Procedures for collecting, identifying, processing, and disposing of specimens**

LB.1.7   **Norms and ranges for all relevant tests**

LB.1.8   **Laboratory safety program, including infection control**

LB.2   **There is qualified supervision of laboratory functions during and after normal work hours.**

LB.3   The head of the laboratory has at least an M.Sc. degree in clinical pathology.

LB.4   **All laboratory staff including technicians are certified and licensed.**

LB.4.1   **All laboratory staff including technicians have training and experience as required by law and regulations and by their job description.**

LB.5   *Twenty-four hour laboratory coverage is provided to meet routine and emergency needs of patients, or coverage is provided as appropriate to the types of services offered by the hospital and its size.*

LB.6   Referral laboratory services are available for tests not available in the hospital through formal or informal contracts.

LB.6.1   The referral laboratory is licensed and accredited by MOHP.

LB.7   **The tests are appropriate to the size of the hospital and its scope of services.**

LB.7.1   There is a written list of laboratory test that are currently available.

LB.8   **Tests are reported in an acceptable timeframe and signed by the laboratory doctor when the test requires professional interpretation.**

LB.9   All laboratory results are documented in the laboratory and reviewed by a lab supervisor every day.

LB.10   **All laboratory test result/reports have reference (normal) ranges specific for age and sex.**

LB.11   *Reporting of significantly abnormal values is documented. The documentation includes the following:*

LB.11.1   **Name of patient**

LB.11.2   **Date and time of sample examination**

LB.11.3   **Date and time of notification of the abnormal result**

LB.11.4   **Name of the individual to whom the result was reported**

LB.12 All surgically removed tissue is sent for pathologic examination. The examination may be done at the hospital or in a reference laboratory. The hospital *may* have a list of approved exceptions of surgical specimens that do not have to undergo pathology examination.

LB.13 **All completed pathology reports contain gross and microscopic description and diagnosis as relevant to the specimen.**

LB.14 **Cytology services are performed according to written procedure, and are supervised by a pathologist or other qualified physician.**

LB.15 **There is a written chemical hygiene plan that defines the safety procedures to be followed for all hazardous chemicals used in the laboratory. The plan defines at least the following:**

LB.15.1 The storage requirements

LB.15.2 Handling procedures

LB.15.3 Requirements for personal protective equipment

LB.15.4 Procedures following accidental contact or overexposure

LB.15.5 The plan is reviewed annually, and updated if needed, and is part of new employee orientation and the continuing education program.

LB.16 When chemicals and reagents are ordered, steps are taken to determine the hazards and to transmit that information to those who will receive, store, use, and dispose of these chemicals.

Radiology

RD.1 *The hospital has written current radiology policy and procedures that cover at least the following:*

RD.1.1 **A radiation safety program**

RD.1.2 **Timeliness of the availability of diagnostic imaging procedures and the results**

RD.1.3 **A quality control program covering the inspection, maintenance, and calibration of all equipment**

RD.2 The radiology department follows all the guidelines developed by MOHP.

RD.3 **Radiology services are authorized by MOHP and are operated according to applicable laws and regulations of the Executive Office of Radiation Protection.**

RD.4 **A qualified individual(s) is responsible for managing the radiology services.**

RD.5 The radiology department is covered 24 hours a day by a radiologist and technician, according to MOH rules and regulations.

RD.6   **The radiology department has adequate supplies and equipment for its function according to MOHP regulations and the scope of services provided.**

RD.7   The radiology department has adequate space according to MOHP regulations and the scope of services provided.

RD.8   **All diagnostic equipment is regularly inspected, maintained, and calibrated, and appropriate records are maintained.**

RD.9   **Individuals with adequate training, skills, orientation, and experience administer the tests and interpret the results.**

RD.10   **The department has defined special techniques or procedures that must be done under physician supervision.**

RD.11   **A radiation safety program is in place, followed, and documented.**

RD.12   **Reporting of radiation safety program findings is timely.**

RD.13   **Medications needed for emergency treatment for any reaction caused by injectable contrast media are readily available in the room.**

RD.14   **The radiology report of examination is kept in patient's medical record.**

RD.15   **Duplicate copies of all reports are kept in the department.**

RD.16   **The department has defined the timeframe for reporting interpretation of radiology tests and procedures, and the timeframes include both emergency and routine reports.**

RD.17   There is a register book in which all (simple and complicated) cases are written**.**

RD.17.1   Information includes the procedure done and the number of films taken.

RD.17.2   The department keeps data on the number of film "retakes" because of inadequate technical quality

4. Patient Care

Introduction

The previous chapter is the basis for patient care. The processes of patient care include planning care, providing care, evaluating the patient's response to care, and planning follow-up care. Care may be provided in multiple locations, by multiple disciplines, and it may involve different processes.

This chapter outlines the care processes for the following:

- ▲ Care planning and coordination
- ▲ Surgical care
- ▲ Anesthesia care
- ▲ Medication use
- ▲ End of Life Care
- ▲ Blood use
- ▲ Emergency care
- ▲ Newborn care

General Care

GC.1   *All care is planned and documented.*

GC.1.1   The care plan includes all disciplines that are providing care to the patient**.**

GC.2   There are policies and procedures for the care of special patients, including the following:

GC.2.1   Patients who are comatose or on life support

GC.2.2   Patients on dialysis

GC.2.3   Patients who must be restrained

GC.2.4   **Patients with communicable diseases.**

Surgical Care

SC.1   *All surgical procedures (except in life-threatening emergencies) are performed only after appropriate history, physical examination, and indicated diagnostic tests have been completed and documented in the patient's medical record.*

SC.2   The preoperative diagnosis has been recorded in the medical record for all patients prior to surgery.

SC.3   *Except in life-threatening emergencies, the surgeon must have obtained an informed consent and this must be documented in the patient's medical record.*

SC.4   The nursing care of patients undergoing surgery must be planned and documented in the medical record, directed by a trained nurse, and include the following:

SC.4.1   Location of post-operative care

SC.4.2   Type of care and monitoring needed

SC.4.3   Pain management

SC.4.4   Patient's understanding of discharge instructions (if being discharged home).

SC.5   *Operative reports are written in the patient's record immediately after surgery and include at least the following:*

SC.5.1   **The procedure performed**

SC.5.2   **Findings during surgery**

SC.5.3   **Post-operative diagnosis**

SC.5.4   **Surgical specimens removed**

SC.5.5   Name of surgeon and anesthesiologist and any assistants

SC.5.6   Signature of the surgeon

SC.6   There is a process to positively identify the patient and ensure that the correct procedure and the correct side are confirmed prior to starting the surgery.

SC.7   *There are processes and policies defining the appropriate safety before and during surgery, including at least the following:*

SC.7.1   Aseptic technique

SC.7.2   Sterilization and disinfections

SC.7.3   Selection of draping and gowning

SC.7.4   Counting of sponges, instruments, and needles

SC.8   There are supplies, equipment, and instruments available for all surgeries performed according to the MOHP list.

Anesthesia and Sedation Care

AN.1   **Anesthesia care, which includes moderate and deep sedation, is planned and documented in the patient's record.**

AN.2   *A pre-anesthesia/sedation assessment has been done by a qualified physician or surgeon prior to the induction of anesthesia.*

AN.2.1   The assessment determines that the patient is a safe candidate for anesthesia or moderate or deep sedation.

AN.2.2   The patient is reassessed immediately prior to induction of anesthesia by an anesthesiologist.

AN.3   The plan is consistent with the patient assessment and includes the anesthesia to be used and the method of administration.

AN.4   **Prior to administration of any pre-anesthesia medication, an informed consent for the use of anesthesia must be obtained and documented in the medical record.**

AN.5   *Each patient's physiologic status is continuously monitored during anesthesia or sedation administration and the results of the monitoring are documented in the patient's medical record on an anesthesia form.*

AN.5.1   **The monitoring includes pulse rate and rhythm.**

AN.5.2   **The monitoring includes blood pressure.**

AN.5.3   **The monitoring includes oxygen saturation.**

AN.5.4   **The monitoring includes respiratory rate.**

AN.6   **The anesthesia record includes medications administered.**

AN.6.1   **The anesthesia record includes fluids administered.**

AN.6.2   **The anesthesia record includes blood or blood products administered.**

AN.6.3   **The anesthesia record includes the actual anesthesia used (if different from the plan).**

AN.6.4   **The anesthesia record includes any unusual events or complications of anesthesia.**

AN.6.5   **The anesthesia record includes the condition of the patient at the conclusion of anesthesia.**

AN.6.6   **The anesthesia record includes the time of start and finish of anesthesia.**

AN.7   *The patient is monitored during the post-anesthesia/surgery recovery period and the results of monitoring are documented in the patient's medical record.*

AN.7.1   The time of arrival and discharge from anesthesia recovery are recorded.

AN.8   **Patients are recovered from anesthesia/sedation in an area that has at least the following:**

AN.8.1   Qualified nurses

AN.8.2   **Equipment as required by MOH regulations, but at least the following:**

AN.8.3   **Oxygen source**

AN.8.4   **Ability to monitor O2 saturation**

AN.8.5   **Suction**

AN.8.6   **Ability to monitor blood pressure, pulse, and heart rate and rhythm**

AN.9   **The anesthesiologist, or other qualified physician, must make the decision to discharge the patient from post-anesthesia care and this decision must be based on documented results of monitoring during anesthesia recovery.**

AN.9.1   **The anesthesiologist, or other qualified physician, must sign the discharge order.**

Medication Use and Pharmacy Services

MU.1   **The pharmacy and medication use practices comply with applicable laws and regulations.**

MU.2   **The hospital has written policies and procedures for at least the following:**

MU.2.1   **Acquisition of medications, including when the pharmacy is closed**

MU.2.2   **Safe prescribing, ordering, storage, administration, and monitoring of the effect of medications**

MU.2.3   **Who may order and who may administer medications**

MU.2.4   Where medication orders are uniformly written in the medical record

MU.3   **A licensed pharmacist is available at all times and is responsible for supervising all pharmaceutical services.**

MU.4   There are sufficient certified pharmacists and support personnel to meet the needs of the hospital.

MU.5   **Pharmacists actively participate in developing and monitoring implementation of the hospital policy on antibiotic and other medication usage.**

MU.6   *There is a system to ensure availability, safety, and security of required emergency and lifesaving drugs 24 hours a day.*

MU.7   *There are written policies for distribution and control of narcotics in compliance with laws and regulations.*

MU.8   Pharmacists actively participate in the quality improvement program related to pharmacy services and related medication use activities.

MU.9   *Medication dispensed from the pharmacy is labeled with at least the following before being administered to the patient*:

MU.9.1   **The patient's name**

MU.9.2   **The name of the drug and its concentration/strength**

MU.9.3   The expiration date

MU.9.4   **Written instructions for use/administration**

MU.10   Outpatients receive appropriate information about the prescribed drug from a pharmacist and information is given in a language and form that the patient can understand. The information includes at least the following:

MU.10.1   Direction on the use and administration of the drug

MU.10.2   Potential significant side effects

MU.10.3 The importance of following the directions

MU.11   For inpatients, the pharmacist ensures that the medication is appropriately labeled and provides information to nursing and medical staff on the medication's use, administration, and side effects, including potential adverse reactions.

MU.12   **The hospital has a medication recall system.**

MU.13   **There are defined written processes and procedures to dispense medications that ensure the medication is given according to the following:**

MU.13.1   **To the right patient**

MU.13.2   **The right drug**

MU.13.3   **In the right dose**

MU.13.4   **By the correct route of administration**

MU.13.5   **At the right time**

MU.14   **The hospital has a written definition of a medication error. The definition includes the following:**

MU.14.1   Medication given to the wrong patient

MU.14.2   **The wrong medication administered**

MU.14.3   Medication given in the wrong dose

MU.14.4 Medication given by the wrong route of administration

MU.14.5 Medication given at the wrong time, including missed doses

MU.14.6 **The definition has been provided to nursing, pharmacy staff, and to all physicians**

MU.15 **There is a system for reporting medication errors.**

MU.15.1 The hospital leadership creates a "blame-free" process for reporting**.**

MU.15.2 Aggregate data about medication errors are analyzed to identify ways to reduce the most common type of errors.

MU.16 **The Essential Drug List (EDL) is adopted and listed by generic name.**

MU.16.1 The EDL includes all therapeutic groups of drugs.

MU.16.2 The EDL is distributed to all physicians**.**

MU.16.3 The EDL is updated at least annually.

End of Life Care

ELC.1 There are policies for managing end-of-life care and they include at least:

ELC.1.1 Management of symptoms, including pain.

ELC.1.2 Provision, if applicable, of support for psychosocial and spiritual needs and support to the family.

Blood Bank and Transfusions Services

BB.1 *The hospital has written polices and procedures for hospital blood bank services that cover all services offered***.**

BB.2 **All hospital blood bank staff including technicians are certified and/or licensed and have appropriate training and experience.**

BB.3 **Hospital blood bank supplies and equipment are adequate for its function.**

BB.4 **Blood and blood products are maintained to meet the amount specified by the hospital according to the size of the Hospital and its scope of services.**

BB.5 **A record is kept to ensure easy tracing of a unit of blood from drawing (or receipt) until final disposition.**

BB.6 **Testing of donors is performed as per routine acceptable standards for screening of communicable diseases and blood type and Rh.**

BB.7   *There are specific written procedures that are followed for all blood bank tests done in the hospital.*

BB.8   **Blood and blood components are collected, stored, and handled in such a manner that they retain their maximum potency and safety.**

BB.9   **There is a written policy on screening of blood donors that follows the national selection criteria.**

BB.10   *All blood products are labeled with at least the identification number, name of the product, required storage condition, expiration date, production date, and name of the blood bank.*

BB.11   **Blood warming systems are monitored so that blood is not warmed above 38ºC.**

BB.12   **Donor blood not intended for preparation of platelets is refrigerated at a temperature of 2º to 6º C.**

BB.13   **Frozen plasma components are stored at a temperature of -18º C or below.**

BB.14   **Refrigerators or freezers in which blood, blood components, or derivatives are stored are used only for storage of donor samples, patient samples, or blood bank reagents.**

BB.15   **Refrigerators and freezers for storage have central electronic monitors or 24-hour chart recorders to ensure all blood and components are continuously stored at acceptable temperature.**

BB.15.1   **If there is no continuous automated recording, temperatures are manually recorded at least every four hours.**

BB.15.2   **The recorded temperature on all systems is checked at least once daily.**

BB.16   **Temperature recording charts and manual temperature logs show at least the following:**

BB.16.1   **Identity of the refrigerator or freezer**

BB.16.2   **Dates of temperature reading**

BB.16.3   **There is a policy on how blood is to be stored outside the blood bank prior to administration.**

BB.16.4   **Acceptable temperature range**

BB.16.5   **Identity of personnel inserting/removing charts or logging temperatures**

BB.16.6   **Any temperature fluctuations falling outside acceptable range**

BB.16.7   **Name and telephone number of person to be notified when malfunction occurs**

BB.16.8   Action taken

BB.17   **There are written procedures to follow if temperature limits are exceeded.**

BB.17.1   These instructions are posted on or near the refrigerator or freezer.

BB.18   **There is an alarm system, which is tested at least once per week.**

BB.18.1   **The tests are documented.**

BB.19   *There are defined procedures to ensure positive identification of the patient prior to obtaining a specimen for typing and cross-matching and before administration of blood.*

Emergency Care

EM.1   The physical location of the emergency room must support at least the following:

EM.1.1   Ready access by ambulance, car, or walking

EM.1.2   Readily identified by signage both within the hospital and from the outside

EM.1.3   Ease of access to other services such as X-ray

EM.1.4   Entrance and exit without going through other areas of the hospital

EM.2   *The facility ensures the presence of qualified staff 24 hours a day.*

EM.2.1   The hospital has a plan of how to staff the emergency room.

EM.3   **All emergency room staff are trained in CPR (cardiovascular resuscitation), emergency care, and the use of emergency equipment.**

EM.4   **The record of every patient receiving emergency care includes at least the following:**

EM.4.1   Time of arrival

EM.4.2   Conclusions at termination of treatment

EM.4.3   Patient's condition at discharge

EM.4.4   Follow-up care instructions

EM.5   The hospital must have and use clinical guidelines on emergency care. The guidelines must include at least the following:

EM.5.1   Emergency stabilization and treatment of chest pain

EM.5.2   Emergency stabilization and treatment of shock

EM.5.3   Emergency stabilization and treatment of polytrauma

EM.5.4   Two additional guidelines for the most common diagnoses or presenting complaints

EM.5.5   The clinical guidelines must be reviewed at least every two years and updated when indicated by current literature.

EM.6   **Essential emergency equipment, as required by MOHP rules and regulations, is available and in good working order.**

EM.7   **EDL medications and lifesaving drugs for emergency care must be available and secure at all times in each emergency room area.**

EM.8   **Support diagnostic services are available 24 hours a day.**

EM.9   **All hospitals either have an ambulance or have an arrangement for ambulance services.**

EM.10   **The hospital ensures that the ambulance service meets the requirements of the MOHP rules and regulations.**

EM.11   The hospital should have an emergency plan to deal with internal disasters such as the arrival of one or more seriously injured patients. The plan should include the following:

EM.11.1 A list of emergency response members, including physicians, nurses, and technicians for laboratory and radiology, and the list is posted in the emergency room

EM.11.2 The ability of the team to able to reach the emergency room within half an hour.

EM.11.3 A list of referral centers

EM.11.4 A plan to mobilize hospital staff and distribute responsibilities among them

EM.12   *The hospital has a plan and process for responding to resuscitation   emergencies anywhere in the hospital, which includes personnel who will respond; required emergency lifesaving drugs, including their location, types, and security; and required equipment.*

Baby-Friendly Care

BC.1   **In hospitals with mother-baby units, care is provided according to clinical guidelines as noted in QI.6.3.1–QI.6.3.3.**

BC.2   **There is a clinical guideline for supporting and encouraging breastfeeding that follows the recommendations of UNICEF and the World Health Organization (WHO).**

5. Clinical Safety

Introduction

Protecting patients, family members, visitors, and staff members from harm of infection or other injury is a fundamental responsibility of all hospitals. Prevention of hospital-acquired infections, including those that are a result of inadequately sterilized equipment and supplies, is the cornerstone of this responsibility.

This chapter describes the following processes:

- ▲ Prevention and control of infection

- ▲ Sterilization of equipment and supplies

- ▲ Evaluation of employee health

Infection Control

IC.1 *The hospital has an active program to reduce the risks of nosocomial infections.*

IC.1.1 **The program covers patients, staff, and visitors.**

IC.1.2 The program is based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.

IC.2 **The hospital has established a functioning infection control committee.**

IC.3 **All relevant disciplines are represented on the committee.**

IC.4 *(5)* **There are clear terms of reference for the infection control committee. The terms of reference include the following:**

- ▲ **Approving the qualifications of the infection control nurse and physician**

- ▲ **Approving the surveillance activities**

- ▲ **Reviewing, aggregating, and analyzing infection control data**

- ▲ **Taking or recommending action (including education) when infection control issues are identified**

- ▲ **Reviewing the effectiveness of these actions**

- ▲ **Periodically reviewing the infection control plan and program**

IC.5   A qualified physician oversees the infection control activities.

IC.6   A qualified nurse (at least one) assists in infection control activities.

IC.7   **The hospital has identified those procedures and processes associated with increased risk of infection. At a minimum, these include the following (when relevant to the hospital's services):**

IC.7.1   **Respiratory tract infections associated with intubation, ventilator support, or tracheostomy**

IC.7.2   **Urinary tract infections associated with catheters;**

IC.7.3   **Blood stream infections associated with intravascular devices**

IC.7.4   **Surgical wound infections**

IC.8   **The hospital has written infection control policies and procedures. The policies and procedures are followed and include, but are not limited to, the following:**

IC.8.1   **Handwashing**

IC.8.2   Isolation policy, including the management and reporting of patients with suspected communicable diseases

IC.8.3   Management of patients who are immunocompromised

IC.8.4   Prevention of blood-borne infections among hospital staff, including disposal of sharps

IC.8.5   **Prevention of surgical sites infection**

IC.8.6   **Prevention of hospital-acquired respiratory tract infections**

IC.8.7   Selection and uses of antiseptics and disinfectants

IC.8.8   **Infection control surveillance and data collection**

IC.8.9   **Management of outbreaks of infections**

IC.8.10   Policies for specific high-risk areas applicable to the hospital, including, but not limited to, the following:

  ▲ Operating theatre

  ▲ Neonatal units

  ▲ Burn units

  ▲ Laboratory

  ▲ Emergency department

- ▲ Dialysis units

- ▲ Intensive care units

- ▲ Organ transplantation units

- ▲ Kitchen

- ▲ Laundry

- ▲ Post-mortem areas

- ▲ Sterilization areas

- ▲ Patient-related procedures such as central line insertion and urinary catheters

- ▲ Policies for patient ventilator management

- ▲ Policies for staff health

- ▲ Disposal of infectious waste and body fluids

- ▲ Policies on management of hemorrhagic patients

- ▲ Hospital cleaning policy

- ▲ Cultures surveillance in high-risk areas (operating rooms, nurseries, ICU, and others)

- ▲ Training of staff

IC.9   **Infection control policies and procedures are disseminated to all concerned departments after being approved by the infection control committee.**

IC.10   **Infection control policies and procedures are reviewed and updated regularly by the infection control committee at least every two years, and the review is based on current professional literature.**

IC.11   **All relevant staff have been oriented and trained in the applicable infection control policies and procedures as relevant to their position or job.**

IC.12   When relevant to the hospital's services, there are special isolation rooms in the hospital, including negative pressure rooms, for isolating infection cases.

IC.13   **There are hand hygiene facilities in each isolation room.**

IC.14   **The surveillance data of hospital-acquired infections, and the effectiveness of the program, are regularly aggregated and analyzed by the infection control committee.**

IC.14.1   **The results are disseminated to senior management to concerned departments or units and, when relevant, are utilized by them for improving the quality of care.**

IC.15   **All communicable diseases are reported as required by MOHP regulations.**

Sterilization

ST.1   The hospital has a central sterilization supply department (CSSD) or defined unit.

ST.1.1   The department is managed by an individual who is qualified by education and/or training.

ST.2   **The functions of cleaning, processing, and sterile storage and distribution are physically separated.**

ST.3   In all areas where instruments are cleaned there must be airflow that prevents cross-contamination and prevents contaminated material from exiting the area.

ST.4   There are means of preventing cross-contamination in the cleaning area.

ST.5   *Based on the services provided and the size of the hospital, the sterilization area has at least one functioning autoclave.*

ST.6   **Boiling water is not used as a sterilization technique.**

ST.7   Whatever sterilization technique is used (including chemical cleaning/sterilization of scopes), there is documented evidence that complete sterilization has been accomplished.

ST.8   **There are specific policies and procedures that are followed for each sterilization technique or device used, including manufacturer's manuals.**

ST.9   There is documented evidence in their human resources file that staff are trained in these procedures.

ST.10   **Policies and procedures have been developed and used for all processes, including the following:**

ST.10.1   Receiving, disinfection, and cleaning of used items

ST.10.2   Preparation and processing of sterile packs

ST.10.3   Appropriate inventory levels

ST.10.4   Emergency ("flash") sterilization

ST.10.5   Expiration dates for sterilized items

ST.10.6   Storage of sterile supplies

ST.11   *Quality control processes and all policies and procedures are uniformly applied in all areas where sterilization is done.*

EH.1 **The hospital has an employee health program that is described in policies and procedures and covers all new and all existing employees, and the program conforms to government laws and regulations.**

EH.2 **The hospital has policies and procedures that have been implemented to identify and deal with occupational hazards.**

EH.2.1 The hospital has completed and documented an occupational hazard survey.

EH.2.2 The employee health program is based on this survey and on government laws, rules, and regulations.

EH.3 *Each current employee who may have direct or indirect contact with patients has an evaluation as required by law or by the hospital (as relevant to the occupational hazards for each department and job position).*

EH.3.1 The employees are reevaluated periodically as required by law and regulation or by the hospital.

EH.3.2 **When screening results or investigations are positive, there is a policy that guides the action to be taken.**

EH.4 *Each new hire who might have direct or indirect contact with patients has a complete pre-employment evaluation as required by law or by the hospital (as relevant to the occupational hazards for each department and job).*

EH.4.1 **When screening results or investigations are positive, there is a policy that guides the action to be taken.**

EH.5 **The hospital staff is trained in occupational health hazards and safety procedures, the training is included in initial orientation, and additional training is provided when new procedures or equipment presents new hazards.**

6. Environmental Safety

Introduction

For patients to receive quality care in a safe environment, hospitals must devote their attention to managing the physical environment and assets such as equipment and utilities. The hospital must have plans for managing the safety of the environment, must implement these plans, must train all relevant staff in their responsibilities, and must collect and analyze data to determine the effectiveness of the plans.

This chapter defines the hospital's responsibility for the following:

- ▲ General safety

- ▲ Fire safety

- ▲ Emergency response

- ▲ Hazardous materials and waste

- ▲ Medical equipment

- ▲ Utility systems

- ▲ Training of relevant staff

ES.1 **The hospital is aware of all laws, regulations, and facility inspection requirements that relate to management of the physical environment, and the leadership has ensured compliance.**

ES.2 *The hospital has an overall plan to manage the physical environment. The plan includes at least the following:*

ES.2.1 **General safety and security**

ES.2.2 **Fire and smoke safety**

ES.2.3 **Emergency response**

ES.2.4 **Hazardous materials and waste**

ES.2.5 **Medical equipment**

ES.2.6 **Utility systems**

ES.2.7 Training of relevant staff

ES.3   *The plan has been implemented.*

ES.4   **All seven components of the overall plan are monitored with collection, aggregation, and analysis of data to identify areas for correction.**

ES.5   All programs are operated continuously.

ES.6   **There is an overall plan and implemented program to manage general safety and security.**

ES.6.1   **The hospital has a documented, current, and accurate inspection of its physical facilities.**

ES.6.2   **There are measures to protect against infant abduction and to protect patients, visitors, and staff from harm, including assault.**

ES.6.3   There is a plan for correction of identified deficiencies in safety and security. The plan includes priorities for correction.

ES.6.4   The plan for correction is being implemented.

ES.7   *There is a fire and smoke safety plan and an implemented program that addresses prevention, early detection, response, and safe exit when required by fire or other emergencies. The plan addresses at least the following:*

ES.7.1   **Frequency of inspecting fire detection and suppression systems**

ES.7.2   **Maintenance and testing of fire protection and abatement systems**

ES.7.3   At least annual testing of the facility evacuation plan

ES.7.4   Documentation of staff training in fire response and evacuation

ES.7.5   Enforcement of the law prohibiting smoking in the hospital

ES.7.6   Documentation of all inspections, maintenance, testing, and training

ES.8   **There is an emergency preparedness plan to respond to likely community or internal emergencies.**

ES.8.1   **The plan for response to external emergencies plan is developed according to government guidelines relating to the responsibility of the hospital in the event of an external emergency.**

ES.8.2   The plan for response to internal emergencies includes a personnel recall system; alternate care sites, if needed; and alternate sources of medical supplies, utilities, and communication.

ES.8.3   The hospital has tested its plan.

ES.9   *There is a hazardous materials and waste management plan for the use, handling, storage, and disposal of hazardous materials and waste. The plan includes at least the following:*

ES.9.1   **An inventory of the types and locations of hazardous materials and waste**

ES.9.2   Safety requirements for the handling, storage, and response to spills or exposures

ES.9.3   Disposal in accordance with applicable laws or regulations

ES.9.4   **Labeling of hazardous materials and waste;**

ES.9.5   Monitoring data on incidents to allow corrective action

ES.10   *There is a plan and an implemented program for inspecting, maintaining, and testing medical equipment. The plan includes at least the following***:**

ES.10.1   **Inventory of all medical equipment**

ES.10.2   **Schedule for inspection and preventive maintenance according to manufacturer's recommendations**

ES.10.3   Testing of all new equipment before use and repeat testing when required

ES.10.4   Data about frequency of repair or equipment failure.

ES.11   *There is a plan and an implemented program for regular inspection, maintenance, and repair of essential utilities. The plan covers at least the following:*

ES.11.1   **Electricity, including stand-by generators**

ES.11.2   **Water**

ES.11.3   **Heating, ventilation, and air conditioning**

ES.11.4   **Medical gases**

ES.11.5   **Communications**

ES.11.6   Waste disposal

ES.11.7   Regular inspections

ES.11.8   Regular testing

ES.11.9   **Regularly scheduled maintenance**

ES.11.10 Correction of deficiencies identified

ES.12   For each plan, there is documentation that appropriate staff members have been trained.

ES.12.1   The staff's knowledge is periodically evaluated**.**

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7. Support Services

Introduction

Although direct provision of care is the primary function of a hospital, its patients and staff are dependent on support services to ensure safe care that is satisfying to patients. One of the more critical requirements in maintaining a safe environment for patients and staff and reducing the risk of hospital-acquired infections is the cleanliness of the hospital and the cleanliness and proper management of linen. In addition, the hospital must ensure that patients receive adequate meals that are nutritious and safely stored and prepared.

This chapter defines the requirements for the following support services:

- ▲ Housekeeping, including standardized cleaning procedures, infection control committee oversight, and adequate training

- ▲ Food service, including sources of food, storage, preparation, and distribution

- ▲ Laundry and linen services, including safe handling of contaminated linen and safe cleaning and distribution

Housekeeping

HK.1 *The hospital has standardized procedures for cleaning, including instructions for the use of disinfectants.*

HK.1.1 **The procedures are described in policies that have been approved by the infection control committee.**

HK.1.2 The policies include at least a cleaning schedule, cleaning and disinfection solutions to be used in various areas, high-risk area policies, and specific general cleaning procedures to be used, including specific areas where dry sweeping is permitted.

HK.2 **All cleaning staff are aware of cleaning procedures and have been trained in proper techniques.**

HK.3 There is an adequate supply (three months) of approved cleaning material and disinfectants**.**

HK.4 The housekeeping supervisor ensures there is an adequate number of cleaning staff per shift according to the size of the hospital and the scope of services it provides.

Food Service and Kitchen

FS.1   *The kitchen and food services are managed according to applicable laws and regulations, and hospital leaders are knowledgeable of these laws and regulations and ensure compliance.*

FS.2   There are policies and procedures that have been implemented and include at least the following:

FS.2.1   A current list of acceptable suppliers of foodstuff and supplies

FS.2.2   Appropriate storage of perishable food and nonperishable items, including expiration dates

FS.2.3   **Standards of sanitation for all food handlers**

FS.2.4   **Procedures, which have been approved by the infection control committee, for cleaning and/or sterilization of all items used in food preparation**

FS.2.5   A kitchen safety program, including fire prevention and suppression

FS.2.6   A list of all special diets available

FS.2.7   A schedule for meals and a process to ensure their timely distribution

FS.2.8   In conjunction with nursing and medical staff, a policy on how to deal with food brought in by family members

FS.3   The kitchen and food service manager maintains a work schedule that ensures that there is an adequate number of staff for each shift**.**

FS.4   All food service workers are trained.

Laundry and Linen Services

LL.1   *Laundry and linen services are operated according to specific policies and procedures. These policies, all of which must have been approved by the infection control committee, include at least the following:*

LL.1.1   Collection of soiled linen

LL.1.2   Specific procedures for handling, including labeling, of materials contaminated with hazardous materials or body fluids

LL.1.3   Policies and procedures for cleaning of contaminated materials

LL.1.4   Cleaning supplies approved by the infection control committee for use

LL.1.5   Quality control program, including measure of water temperatures

LL.1.6   Storage and distribution of clean linen

LL.2   **There is at least one fully functioning automatic washing machine.**

LL.3   Adequate supplies and washing detergents are available.

LL.4   **Contaminated linen is separated from clean linen.**

LL.5   The laundry supervisor ensures that sufficient staff are available for each shift.

LL.6   **All laundry workers are trained.**

LL.7   **If laundry and linen services are performed through an outside contract, there must be documentation that the requirements of standards LL.1–LL.6 are met by the contractor (also see ML.4.7).**

8. Quality Improvement and Patient Safety

Introduction

The quality improvement and patient safety standards found in this chapter may be the most important of all the standards. Continuous improvement and constant concern over reducing the risks to patients identify hospitals that are committed to the welfare of their patients. To improve quality and reduce risks, the hospital must constantly evaluate (measure) its performance and use that information to identify ways in which it can improve. This self-evaluation must be planned and ongoing and should focus on systems and processes, not solely on individual performance. To be successful, the hospital leadership must ensure that the climate does not allow focus on "who is to blame." To be able to effectively improve quality of care, the hospital must collect, aggregate, and analyze data concerning its current performance. Quality is improved when the hospital ensures that care follows "best practices" that are based on professional literature and not on individual opinion or routine. The hospital must also be able to identify significant unexpected or adverse events and intensively analyze them to understand their underlying causes and, as a result, make the necessary effective changes.

This chapter defines the requirements for the following areas to help improve quality and reduce risks:

- ▲ A planned and hospitalwide approach

- ▲ The required structure (committee)

- ▲ The development and implementation of clinical guidelines

- ▲ Measurements (data collection) for both clinical and managerial indicators of quality

- ▲ Identification and analysis of significant events

QI.1 *The hospital has a quality improvement and patient safety committee assigned to improving the quality of care at the hospital.*

QI.1.1 **The committee is chaired by the hospital director.**

QI.1.2 **The membership is multidisciplinary and includes senior members of the medical and nursing staff, other department representatives, and the QI coordinator.**

QI.1.3 There are terms of reference for the committee, which include the following:

QI.1.3.1 Ensuring that all departments participate

QI.1.3.2 Establishing hospitalwide priorities for improvement

QI.1.3.3 Ensuring that all required measurements are done

QI.1.3.4   Reviewing the analysis of aggregate data, including the frequency of data collection and analysis

QI.1.3.5   Using authority to direct action in response to identified quality improvement or patient safety issues

QI.1.3.6   Reporting information both upward to leaders and downward to staff members.

QI.2   *There is an assigned quality improvement coordinator whose role is to coordinate QI activities.*

QI.2.1   The QI coordinator is a member of all relevant hospital committees.

QI.2.2   **There is a written job description for the QI coordinator.**

QI.3   *The hospital has a written quality improvement and patient safety plan. The plan includes at least the following:*

QI.3.1   **A description of the methodology to be used**

QI.3.2   **The membership of the quality improvement and patient safety committee**

QI.3.3   **Authority of the committee**

QI.3.4   Criteria for establishing priorities

QI.3.5   **Information flow**

QI.3.6   **Description of required measurements**

QI.4   **There is an incident-reporting policy describing a system with written procedures on the following:**

QI.4.1   List of reportable incidents

QI.4.2   Persons responsible for initiating reports

QI.4.3   How, when, and by whom incidents are investigated

QI.4.4   Corrective action plan and assigned responsibilities

QI.5   **As part of their orientation, all employees receive basic training in the principles and practice of quality improvement.**

QI.6   The hospital has developed, disseminated, and adopted clinical practice guidelines for priority clinical services and procedures provided.

QI.6.1   Clinical practice guidelines are based on current professional literature.

QI.6.2   Relevant staff are educated about the guidelines**.**

QI.6.3 Clinical practice guidelines cover the three most common diagnoses in each medical department.

QI.6.4 Clinical practice guidelines cover the three most common procedures in each medical department.

QI.6.5 Clinical practice guidelines cover at least two high-risk diagnoses and two high-risk procedures (if applicable) in each medical department.

QI.6.6 Each medical department develops and implements at least one additional clinical practice guideline each year.

QI.6.7 Clinical practice guidelines are reviewed at least every two years and are revised when needed based on current professional literature.

QI.6.8 As part of the quality improvement program, the hospital collects, aggregates, and analyzes data about compliance with the clinical practice guidelines**.**

QI.7 **The hospital provides QI training to its staff.**

QI.8 *The hospital monitors clinical care by collection, aggregation, and analysis of data related to at least the following:*

QI.8.1 **Patient assessment**

QI.8.2 **Laboratory and radiology safety and quality control programs**

QI.8.3 **Surgical and invasive procedures**

QI.8.4 **Use of antibiotics, other medications, and medication errors**

QI.8.5 **Use of anesthesia and moderate and deep sedation**

QI.8.6 **Use of blood and blood products**

QI.8.7 **Medical records, including availability and content**

QI.8.8 **Infection control**

QI.8.9 **Adherence to rules on clinical research**

QI.9 Managerial monitoring includes at least the following:

QI.9.1 Procurement of routinely required supplies and medications essential to meet patient needs

QI.9.2 Reports as required by law and regulation

QI.9.3 **Risk management**

QI.9.4 Utilization management

QI.9.5 Patient and family expectations and satisfaction

QI.9.6   Staff expectations and satisfaction

QI.9.7   Patient demographics and diagnoses and procedures

QI.9.8   Finance

QI.9.9   **Identified patient safety issues**

QI.10   Individuals with appropriate experience, knowledge, and skills systematically aggregate and analyze data in the hospital.

QI.11   *Intensive assessment is done when significant unexpected events and undesirable trends and variation occur. Significant events that will be analyzed in detail include at least the following:*

QI.11.1   **Unexpected deaths**

QI.11.2   **Confirmed transfusion reactions**

QI.11.3   **Significant adverse drug reactions that cause harm to a patient**

QI.11.4   **Significant medication errors that cause harm to a patient**

Q.11.5   **Significant anesthesia events that caused harm to a patient**

QI.11.6   **Significant differences between pre- and post-operative diagnoses, including surgical pathology findings**

QI.12   **The hospital data are analyzed and used by hospital management for decision making.**

QI.13   **The governing body, hospital director, and heads of departments actively participate in the planning and monitoring of the quality improvement and patient safety program.**

9. Medical Records

Introduction

The medical record is the source document that allows evaluation of the quality of care, effective communication among all health care professionals, the appropriate transfer of information between units within the hospital and to other hospitals, and continuity of care during and after hospitalization. A poorly documented medical record may mask inadequate care.

Since the medical record is the foundation for nearly all the direct patient-related standards in this manual, this chapter defines the following:

- ▲ Requirements for all medical records, whether inpatient or outpatient

- ▲ Specific requirements for inpatient records

- ▲ Specific requirements for outpatient records

MR.1   *The hospital has a medical record for each patient evaluated or treated.*

MR.2   **Each medical record contains sufficient information to perform the following:**

MR.2.1   Identify the patient, including name, address, and date of birth

MR.2.2   Promote continuity of care

MR.2.3   Support the diagnosis

MR.2.4   Justify the treatment

MR.2.5   Document the patient's course and results of treatment

MR.3   *The hospital and its medical staff have defined in writing the minimum acceptable scope of the history and physical examination, which may vary depending on the patient's needs and the setting of care or the specialty.*

MR.3.1   The hospital and its medical staff have defined in writing the minimum acceptable scope of the comprehensive history and physical examination for inpatient admission for adults and children, including inpatient surgery.

MR.3.2   Outpatient surgery and other invasive procedures

MR.3.3   **Emergency room patients**

MR.3.4   Psychiatry admissions

MR.3.5   Obstetrical admissions

MR.3.6   Inpatient short-stay (less than 48 hours) patients

MR.3.7   Hospital outpatient visits

MR.4   **Results of all diagnostic tests are documented in the patient's medical record and are received within the timeframe established by each department that does diagnostic tests.**

MR.4.1   The timeframes are defined for emergent and routine test results.

MR.5   *All diagnoses are recorded and updated according to the results of investigations and/or reassessments.*

MR.6   *All treatments, including medications administered, are recorded when given and are signed by the person providing the treatment.*

MR.7   **The medical record documents that physicians and/or other health professionals explained to all patients the diagnosis and treatment and any follow-up steps.**

MR.7.1   There is documentation that the physician or other health professional ensured that patients understood the message through feedback.

MR.7.2   There is documented evidence that patients were educated on their diagnosis or condition.

MR.7.3   When relevant to the patient's diagnosis, there is documentation of education concerning diagnostic tests, treatments, medication, and use of any medical equipment.

MR.7.4   When relevant to the patient's diagnosis, there is documentation of education that includes information on risk reduction: diet, exercise, smoking cessation, and other health-related practices.

MR.7.5   When relevant to the patient's diagnosis or condition, education includes community resources available to the patient (diabetic, asthmatic).

MR.7.6   When relevant to the patient's diagnosis or condition, education includes any special education classes.

MR.7.7   When relevant to the patient's diagnosis or condition, education includes food and drug interactions.

MR.7.8   When relevant to the patient's diagnosis or condition, education includes nutrition.

MR.7.9   When relevant to the patient's diagnosis or condition, education includes physical rehabilitation.

MR.8   **All diagnostic and therapeutic orders are authenticated by the appropriate department.**

MR.8.1   There is a policy defining the types of verbal or telephone orders that must be authenticated and the time frame for authentication.

MR.9   *A comprehensive operative note is entered in the medical record immediately after surgery or invasive procedures.*

MR.10   The hospital has defined who is authorized to make entries in the medical record.

MR.11   **The author of all entries in the medical record can be identified by name and title (physician, nurse, physical therapist).**

MR.12   **In event of transfer of the patient to another facility, a copy of the transfer summary written by the physician will go with the patient. The original is placed in the hospital record.**

MR.12.1   The reason for the transfer is explained to the patient.

MR.13   **The hospital uses standardized diagnosis and procedure codes.**

MR.14   *The hospital has a process for review of medical records. The process includes the following:*

MR.14.1   Involvement of representatives of all disciplines who make entries in the medical record

MR.14.2   **Review of the completeness (content) and legibility of entries**

MR.14.3   **Review of a representative sample**

Inpatient Records

MR.15   *A history and physical examination is recorded in the patient's medical record within 24 hours of admission, or earlier, if indicated by the patient's condition.*

MR.16   *The history and physical examination is recorded in the patient's medical record prior to surgery or any invasive procedure.*

MR.17   **If the history and physical examination has been completed prior to admission, a legible copy may be used provided it is no more than 30 days old and the physician enters a note in the medical record defining any subsequent changes, based on reassessment of the patient.**

MR.18   **A comprehensive history and physical examination includes at least the following:**

MR.18.1   **The main complaint**

MR.18.2   **Details of the present illness**

MR.18.3   **Past history including**

MR.18.3.1 Previous admissions and surgery, if applicable

MR.18.3.2 Allergies

MR.18.3.3 Adverse drug reactions, if any

MR.18.3.4 Medications the patient has been taking, if any

MR.18.4 Psychosocial history, including emotional, behavior, and social status

MR.18.5 Family history

MR.18.6 For pediatric patients, the H&P must include the parent's report or other documentation of the patient's immunization status and a growth and development chart for ages established by department policy.

MR.18.7 A comprehensive current physical examination, including vital signs and positive findings

MR.18.8 A statement of the conclusion or impressions drawn from the admission history and physical examination

MR.18.9 The initial management plan, including investigations and treatment

MR.19 Medical progress notes are made by the medical staff with a frequency according to the severity of illness, hospital policy, and patient's condition.

MR.19.1 In all acute care settings, physician's progress notes are made at least once per day.

MR.20 Type of diet provided according to the patient's condition is documented in the medical record.

MR.21 Records of discharged patients are completed within a period of time not exceeding 15 days of the date of discharge.

MR.22 *Patient record must contain a copy of the discharge summary. The discharge summary must include at least the following:*

MR.22.1 The reason for admission

MR.22.2 Significant findings, including investigations

MR.22.3 Procedures performed

MR.22.4 Any diagnoses made

MR.22.5 Medications or other treatments, if applicable

MR.22.6 Patient's condition at discharge

MR.22.7 Discharge medications and follow-up instructions

MR. 23 There is a policy that is followed that defines where in the medical records all orders, including those for medications, must uniformly be written or recorded.

Outpatient Records

MR.24   **The hospital defines the minimum content of outpatient medical records for new patients for comprehensive assessment.**

MR.25   **The hospital defines the minimum content of outpatient medical records for outpatient procedures.**

MR.26   **The hospital defines the minimum content of outpatient medical records for brief illness or injury-related visits.**

MR.27   **The hospital defines the minimum content of outpatient medical records for return visits.**

10. Management of Information

Introduction

Modern health care, and its continuous improvement, is dependent on information. The hospital should have a plan to meet the information needs of its clinical and managerial leaders and to compare its performance with other databases when relevant. The plan should address these needs and should reflect the types of services offered.

IM.1 *The hospital has a written plan or plans to meet information needs. The plan(s) is based on at least the following:*

IM.1.1 The identified information needs of clinical and managerial leaders of the hospital

IM.1.2 The size and the types of services provided by the hospital

IM.1.3 Confidentiality and security of data and information and protection from loss or damage

IM.1.4 Determination of levels of required access to data and information

IM.1.5 Requirement for standardized diagnosis and procedure codes

IM.2 The plan is being implemented**.**

IM.3 Clinical and managerial staff participate in selecting, integrating, and using information management technology**.**

IM.4 The organization has a policy on the retention time of records, data, and information.

IM.5 **Records and information are protected from loss, destruction, tampering, and unauthorized access or use.**

IM.6 **The hospital contributes to external databases in accordance with the law or regulation.**

IM.7 The organization uses external reference databases, including infection control, for comparative purposes.

11. Human Resources

Introduction

Hospitals have many resources, including real estate, buildings, and equipment. In every hospital, however, the most valuable resource is its staff. With that in mind, the hospital must determine its personnel requirements. The responsibility of staff must be defined; they must be carefully selected; their competency must be evaluated before being allowed to work; their orientation must be completed; their continued competency must be periodically assessed; and they must be afforded continued training relating to their responsibilities.

This chapter outlines the requirements for the following items related to human resources:

- ▲ A staffing plan

- ▲ Job descriptions for all types of employees

- ▲ An employee-specific file

- ▲ Periodic reevaluation of the employee's performance

HR.1 **Each department has a written staffing plan. The plan defines the following:**

HR.1.1 The total number of staff members needed to fulfill the department's responsibility

HR.1.2 The types of staff members needed

HR.1.3 The required education, skills, knowledge, and experience required for each position

HR.1.4 The plan is periodically reviewed and updated as required, but at least every two years**.**

HR.2 *Each employee has a current job description. The job description includes the required education, skills, knowledge, and experience and a description of the responsibilities of the individual.*

HR.2.1 **There is documentation in each employee's file that the job description has been discussed with the employee.**

HR.3 There is an implemented process that is uniformly applied for recruiting staff.

HR.4 There is an implemented process that is uniformly applied for evaluating the qualifications of new staff.

HR.5 There is an implemented process that is uniformly applied for appointing new staff members**.**

HR.6   There is an implemented process that is uniformly applied for reevaluation of each category of employees, including the frequency of reevaluation**.**

HR.7   *A personnel file is maintained for each employee. Each file must contain, when applicable to that employee, the following seven elements:*

  ▲   *Copies of diplomas, licenses, certifications*

  ▲   *Work history*

  ▲   *Current job description*

  ▲   *Evidence of orientation to the hospital, the assigned department, and the specific job*

  ▲   *Evidence of initial evaluation of the employee's competence to perform the assigned job*

  ▲   *In-service education received*

  ▲   *Copies of annual evaluations*

HR.8   *(5) There is a formal orientation program for all employees: The program should include three levels of orientation: hospitalwide, departmental, and job specific.*

HR.8.1   Orientation to hospital structure and administration, provided by hospital management.

HR.8.2   Orientation to hospital policies, including all environmental safety programs, infection control, and quality improvement

HR.8.3   Orientation to the assigned department

HR.8.4   Orientation to the specific job within the department

HR.9   There are programs in each department for ongoing in-service training.

HR.9.1   The education is based on evaluation of the employees' needs.

HR.10   **All staff members who provide direct patient care have received training in basic cardiopulmonary resuscitation and the training is repeated at least every two years.**

HR.11   There are facilities and materials appropriate to the identified training needs.

HR.11.1 There is a library with materials appropriate to the services provided by the hospital.

HR.12   The hospital surveys provider and other staff satisfaction at least once per year.

HR.12.1 The data from the survey are aggregated and analyzed at least once per year.

HR.13   Decision makers and other staff members are trained in the principles of information management, as appropriate to their responsibilities or job description**.**

12. Management and Leadership

Introduction

The leadership of any hospital includes its most critical components for fulfilling its mission. Typically this includes the governing body, administration, medical staff, and nursing. To provide quality and safe care, members of the leadership team must work collaboratively. They must understand the hospital's mission and their own responsibilities and work to ensure that clear lines of authority are established and that there are effective means of communication.

This chapter outlines the requirements for the following management and leadership areas:

- ▲ Development of a mission statement

- ▲ Processes for coordination and communication

- ▲ A clear organizational structure that defines authorities

- ▲ The responsibility of the hospital director

- ▲ The responsibility of department heads

ML.1 *The hospital has a clear mission statement developed and agreed upon by the hospital council.*

ML.1.1 The mission statement is made public.

ML.2 **There is a clear system/process for coordination and communication between the director and the staff.**

ML.3 The facility has a clear and written organizational structure with clear lines of authority.

ML.4 *A full-time director is appointed by the governing body and is assigned to manage the hospital in accordance with applicable laws and regulations. The director has a clear written job description. The job description defines at least the following responsibilities:*

ML.4.1 **Providing oversight of day-to-day operations**

ML.4.2 **Ensuring that necessary policies and procedures are developed and approved by the governing body when required**

ML.4.3 **Ensuring that the hospital complies with all laws and regulations**

ML.4.4 **Providing oversight of human, financial, and physical resources**

ML.4.5   **Ensuring that there is a functional, including appropriate resources, hospitalwide program for quality improvement and patient safety**

ML.4.6   **Ensuring appropriate response to reports from any inspecting or regulatory agencies, including accreditation**

ML.4.7   Ensuring oversight of all contract services

ML.5   **The hospital director has appropriate training and/or experience in health management as defined in the job description.**

ML.6   **The hospital director and all department managers ensure that there is a planned, written, and documented orientation program for all employees.**

ML.7   *A department head is assigned to each of the administrative and clinical departments. The responsibility of department heads includes at least the following:*

ML.7.1   Providing a written description of the services provided by the department

ML.7.2   Ensuring coordination and integration of these services with other departments when relevant

ML.7.3   Recommending space, staffing, and other resources needed to fulfill the department's responsibility

ML.7.4   Defining the education, skills, and education needed by each category of employee in the department

ML.7.5   Ensuring that there is an orientation and continuing education program for the department's employees

ML.7.6   Developing and implementing a department quality improvement program

13. Medical Staff

Introduction

The medical staff is the most important component for the provision of quality and safe care. The hospital must have processes to ensure that members of the medical staff are fully qualified to provide only those health care services that are based on their education, training, and experience and demonstrated competence. Since competence may change over time, there must be a clearly defined and uniformly applied process for periodic reevaluation of the performance of each individual member of the medical staff.

This chapter defines the requirements for the following related to medical staff:

- ▲ A process to determine the qualifications of medical staff members and maintenance of a file containing all relevant information

- ▲ Definition of who may be a member of the medical staff

- ▲ A process to determine the specific clinical services (delineated clinical privileges) that each medical staff member is authorized to provide

- ▲ A process to periodically reevaluate the medical staff member's continued competence to provide the authorized clinical services

- ▲ Medical staff participation in quality improvement and safety activities

- ▲ The responsibilities of department heads

MD.1 *The hospital maintains a record for every member of the medical staff that contains a copy of all documents related to license, education, experience, and certification.*

MD.2 **Appointment of medical staff members is done according to the hospital policy, is approved by the governing council, and is in accordance with MOHP rules and regulations.**

MD.3 **The hospital has a written policy, approved by the governing council, for managing medical staff.**

MD.4 **The medical staff includes licensed physicians and dentists and may include other licensed individuals permitted by law to provide patient care services independently in the hospital.**

MD.5 *All medical staff members have delineated clinical privileges that define the scope of patient care services they may provide independently in the hospital.*

MD.6   **All medical staff members and all others with delineated privileges are subject to medical staff rules, regulations, and policies.**

MD.7   **All senior medical staff participate in quality improvement activities in their department and in the hospital.**

MD.8   The performance of all individual medical staff members is reviewed once per year to determine their continued competence to provide patient care services**.**

MD.9   **The hospital has a functioning continuous medical education program All medical staff members receive continuing medical education.**

MD.10   **Each department has a designated head.**

MD.11   The head of the department is certified in an appropriate specialty and has appropriate experience.

MD.12   Each department head has a written job description defining the responsibilities, including active support of the quality improvement and patient safety program.

MD.13   In hospitals participating in professional graduate education programs, physicians in training are supervised by a qualified medical staff member in carrying out their patient care responsibilities**.**

14. Nursing Services

Introduction

Nurses are the only health care professionals who are with the patient 24 hours a day. Their role is critical in nearly all aspects of patient assessment and care. When nurses assume a more active role in evaluating patients and monitoring their response to treatment, outcomes of care are improved. The standards in this chapter set a framework for increasing the role of nursing services.

This chapter defines the following:

- ▲ The role and responsibility of the nurse director/executive, including being a member of the senior leadership team of the hospital

- ▲ An expanded role for nurses in assessing patients and creating a formal plan for nursing care

- ▲ Nursing participation in quality improvement and other important hospital committees

NS.1 *The hospital nurse director/executive is a registered nurse and is qualified by education and managerial experience, as required by the job description.*

NS.2 *The nurse director is a member of the senior leadership team of the hospital.*

NS.2.1 The nurse director attends the senior leadership staff meetings.

NS.3 The nurse executive is responsible for determining nursing standards of practice and their implementation. These standards include at least the following:

NS.3.1 A documented nursing assessment

NS.3.2 A documented nursing diagnosis or diagnoses

NS.3.3 A documented nursing care plan

NS.3.4 Documentation of nursing treatments and reassessments

NS.3.5 Evaluation of the effectiveness of nursing treatments

NS.4 In conjunction with the leaders of the medical staff, the nursing executive determines the scope of nursing assessment.

NS.4.1 There is a written description of the scope of nursing assessment that may vary by unit or type of patient.

NS.4.2 Nurses document directly in the patient's medical record.

NS.5 *The nurse director and other nursing leaders participate with the leader of the governing body, management, and medical staff in the development, ongoing review, and implementation of all relevant hospital plans, programs, and policies.*

NS.6 **The nurse director identifies staffing needs and participates in recruiting plans.**

NS.7 **The nurse director ensures that schedules assigning jobs to the staff members, according to the overall workload, are completed.**

NS.8 **Nursing assignments are made on the basis of the job description and the evaluation of the individual nurse's competence.**

NS.9 **Nurses participate in hospital committees including, but not limited to, the following:**

NS.9.1 Quality improvement

NS.9.2 Infection control

NS.9.3 Drug utilization

NS.9.4 Medical records

NS.9.5 Safety

NS.10 *The nursing department develops and implements written policies and procedures guiding nursing care and specifies type of care they are permitted to provide. These policies and procedures include, but are not limited to, the following***:**

NS.10.1 Scope of nursing assessment

NS.10.2 Infection control

NS.10.3 Basic hygiene

NS.10.4 Safety

NS.10.5 Medication administration

NS.10.6 Parenteral therapy

NS.10.7 Skin care and prevention of pressure sores

NS.10.8 Administration of blood and blood products

NS.11 **There is planned and documented orientation program for new nurses. The plan includes at least the following:**

NS.11.1 Organization policies and procedures

NS.11.2 Nursing department policies and procedures

NS.11.3 Individual job description

NS.11.4 Nursing QI program

NS.11.5 Fire and disaster plan, and safety training

NS.11.6 Infection control policies and procedures

NS.12 **There is a nursing continuing training program in all nursing practice areas.**

NS.13 There is a documented annual training review for all nursing staff in at least infection control, fire and disaster plan, and safety.

NS.14 Nursing care is an essential part of overall patient care process**.**

NS.15 Collaboration of nurses with physicians and other workers for patient care is planned and documented.

NS.16 **Nurses participate in patient education, including during the discharge process.**