MINISTRY OF HEALTH AND SOCIAL SERVICES
NAMIBIA

HOSPITAL QUALITY STANDARDS

1st Edition

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Ministry of Health and Social Services

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A: FOREWORD

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

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

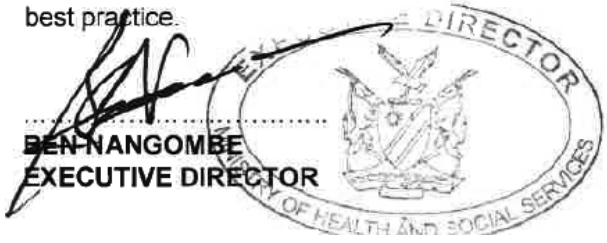
Standards will assist in identifying gaps in the healthcare system at all levels. They further include care coordination issues that affect patients throughout the continuum of care, for example, medication reconciliation, care transitions, patient engagement and education, environmental and equipment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

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

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

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

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



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BEN NANGOMBE
EXECUTIVE DIRECTOR

B: ACKNOWLEDGEMENT

The development of healthcare quality standards was through an extensive consultative process with support, participation, and valuable inputs from individuals in the public and private health sectors, training institutions, and development partners.

Special thanks go to the following institutions:

- Quality Assurance Division, National and Regional Health Directorates, Namibian Standards Institution (NSI), Training Institutions (University of Namibia (UNAM), Welwitchia University, Namibia University of Science and Technology (NUST) International University of Management (IUM),) Namibia Institute of Pathology (NIP), National Health Training Centre (NHTC), Private health care facilities (Roman Catholic Hospital and Rhino Park Private Hospital), United States Agency for International Development (USAID) Namibia, World Health Organization (WHO) Namibia Country Office, IntraHealth International and Health Professions Councils of Namibia (HPCNA), who participated in the consultative workshop during the development of the standards.
- Regional Health Directorates for providing feedback on the draft standards.
- Katutura Intermediate Hospital, Robert Mugabe Clinic, and Khomasdal Health Centre where pilot assessments were conducted and informed the development of the standards.
- The Council for Health Service Accreditation of Southern Africa (COHSASA) consultants for providing technical assistance in the development and finalization of the standards.
- Centres for Disease Control and Prevention (CDC) Namibia for financial support during the development process.

C: GUIDE TO THE USE OF THE STANDARDS

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

1. Structure/Format

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

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

1. Management and Leadership

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

Standards

1.1. Governance of the hospital

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

Standard Intent

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

Criteria

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

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

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

2. Notes on the Standard Interpretation Guidelines

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

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

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

The purpose of these guidelines is to provide guidance on the scope and interpretation of the criterion statement. The information should also provide facility personnel with a clear indication

of the requirements for compliance and some direction on the surveyors/assessors' approach when assessing the evidence of compliance.

3. Definitions of Severity Ratings allocated to criteria

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

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

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

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

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

4. Definitions of Categories allocated to criteria

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

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

2. Legality	1. Mild	In contravention of some policies but unavoidable under the circumstances and accepted by personnel, although not ideal.

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

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

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

Standards are written expectations of structures, processes or performance and it is assumed that if standards are met, better care can be delivered. If standards are substantially met, a facility can achieve certification/accreditation. The standards, in turn, are defined by objective,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Critical criteria

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

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

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

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

D: ADDITIONAL COMMENTS

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

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

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

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

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

D: INTERPRETATION OF TERMS USED IN THE STANDARD ASSESSMENT MANUAL

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

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

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

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

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

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

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

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

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

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

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

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

Risk register	A document containing all identified risks for the facility. Each risk should be rated according to a risk matrix. Each risk should be described in terms of source and nature of the risk. The risk register should also record the available mitigation strategies, existing counter-measures in place, recommended additional counter-measures and the frequency with which the risk should be monitored.
Risk matrix	A risk management tool that allows the ranking of risks according to the severity of the impact of the risk and the probability of the risk occurring.
Safety	The degree to which potential risks and unintended results associated with health care are avoided or minimised.
Seamless continuum of care	In the ideal healthcare system, care is delivered in an integrated, uninterrupted, or 'seamless' flow. It is defined as an integrated, patient-oriented system of care composed of both services and integrating mechanisms that guides and tracks patients over time through a comprehensive array of health, mental health and social services spanning all levels of intensity of care.
Setting	The particular healthcare environment that is appropriate for the patient's needs during the continuum of care, i.e. inpatient care, outpatient attendance, rehabilitative and restorative unit, or community setting.
Staffing establishment	This will include available or approved posts, filled posts and vacant posts.
Staffing plan	This defines the human resource requirements to deliver the desired services.
System	A network of interdependent components that work together to attain the goals of the complex whole (WHO).
Personnel	All individuals employed by the facility – this includes full-time, part-time, casual or contract, clinical and non-clinical personnel.
Personnel development	The formal and informal learning activities that contribute to personal and professional growth, encompassing induction, inservice training and continuing education.
Stakeholder	Individual, organisation or group that has an interest or share in services.
Standards	1. The desired and achievable level of performance corresponding with a criterion or criteria against which actual performance is measured. 2. For the purposes of accreditation, a predetermined expectation set by a competent authority that describes the acceptable level of performance of a healthcare facility or individual in relation to structures in place, conduct of a process, or measurable outcome achieved.

Standard development	Standards for evaluation may be developed in three stages: 1. *Normative development* entails establishing what experts believe should happen. 2. *Empirical standards* reflect what is achievable in practice. 3. A *compromise* between what is professionally optimal and what can reasonably be expected to operate.
Standard, minimum	A predetermined expectation set by a competent authority that describes the minimally acceptable level of: a. structures in place b. performance of a process and/or c. measurable outcome that is practically attainable.
Standard, patientcentred	For the purposes of accreditation, standards that address and are organised around what is done directly or indirectly, for or to patients (for example, creation of patient records, patient assessment).
Standards-based evaluation	An assessment process that determines a healthcare facility or practitioner's compliance with predetermined standards.
Step-down facility	The Joint Commission (*Survey Protocol for Subacute Programmes,* 1995) defines a step-down unit as follows: "At the most complex end of a range of subacute care services are the short-stay, transitional step-down units, which are often, but not always, attached to facilities. These units provide a substitute for continued facility stay. They serve very sick patients, for example, those in cardiac recovery, those in oncology recovery receiving chemotherapy and radiation, or others who need complex wound management or who suffer from complicated medical conditions. These subacute care patients require more than 5 hours of daily nursing, heavy physician involvement, and heavy pharmacy and laboratory support. The average stay is 5–30 days." (See also *subacute care centre*).
Structure	The physical and human resources of a facility.
Sub-acute care centre	The Joint Commission *(Survey Protocol for Subacute Programmes,* 1995) defines subacute care as follows: "Subacute care is goal-oriented, comprehensive, inpatient care designed for an individual who has had an acute illness, injury or exacerbation of a disease process. It is rendered immediately after, or instead of, acute hospitalisation to treat one or more specific, active, complex medical conditions or to administer one or more technically complex treatments in the context of a person's underlying long-term conditions and overall situation. Generally, the condition of an individual receiving subacute care is such that the care does not depend heavily on high technology monitoring or complex diagnostic procedures."
Surveyor	A physician, nurse, administrator or any other healthcare professional who meets COHSASA surveyor selection criteria, evaluates standard compliance and provides consultation regarding standard compliance to surveyed healthcare facilities.
System	The sum total of all the elements (including processes) that interact to produce a common goal or product.

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

Workload measurement	Manual or computerized tool for assessing and monitoring the volume of activity provided by a specific team in relation to the needs for the care and treatment or service they are providing.

HOSPITAL QUALITY STANDARDS

SERVICE ELEMENTS, RELEVANT STANDARDS AND CRITERIA

1 Management and Leadership

OVERVIEW OF MANAGEMENT AND LEADERSHIP

Providing excellent patient care requires effective management and leadership at all levels in a hospital.

Those who provide governance, management and/or leadership have both authority and responsibility. Collectively and individually, they are responsible for complying with Namibian laws and regulations and for meeting the hospital's responsibility to the patient population served.

At the governance level, an entity (e.g., the Ministry of Health and Social Services), owner(s), or group of identified individuals (e.g. a board or governance structure) is responsible for directing the operation of the hospital and accountable for providing quality healthcare services to their catchment population.

At the organisational level (typically the senior management team in a hospital), individuals are assigned the responsibility of ensuring that the policies approved at governance level are implemented. In addition, this level of leadership is responsible for ensuring that systems of administration and organisation are in place to support the provision of excellent patient care.

At departmental and service level, heads of departments and services are responsible for ensuring effective management and leadership of personnel responsible for service delivery. This will typically include ensuring the implementation of policies and procedures, coordination of quality improvement activities within the department, evaluation of personnel performance, etc.

Each hospital must identify these individuals and involve them in ensuring that the hospital is an effective, efficient resource for the community and its patients.
These leaders must identify the hospital's mission and make sure that the resources needed to fulfil this mission are available. For many hospitals this does not mean adding new resources but using current resources more efficiently. This can be achieved even when resources are scarce. To maximise efficiency, leaders must work together to coordinate and integrate all the hospital's activities, including those designed to improve patient care and clinical services.

Effective governance, management and leadership begin with understanding the various responsibilities and authority of individuals in the hospital and how these individuals work together.

Over time, effective management and leadership help overcome perceived barriers and communication difficulties between departments and services in the hospital. As a result, the hospital becomes more efficient and effective and services become increasingly integrated. In particular, the integration of all quality management and improvement activities throughout the hospital should result in improved patient outcomes.

Standards

1.1 Governance of the hospital

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

Standard Intent

The governance structure is responsible for directing the operation of the hospital and accountable for providing quality healthcare services to its catchment population. The responsibilities and accountabilities of this entity should be described in a document that shows how these duties are to be carried out. The responsibilities and accountabilities of the governance structure should be known to those responsible for management within the hospital.

It is important that the hospital has clear leadership, operates efficiently and provides quality healthcare services. The lines of communication to achieve this should be presented in an organisational chart or other document. The identification of individuals in a single organisational chart does not by itself ensure good communication and cooperation between those who govern and those who manage the hospital. This is particularly true when the governance structure is separate from the hospital, such as a distant owner or national or regional health authority. The process for communication and cooperation with the governance structure should therefore be made known to the hospital's managers and used by them.

Responsibilities of the governance structure lie primarily in approving plans and documents submitted by the managers of the hospital. Those elements of management requiring approval by the governance structure should be documented. The relationship of the hospital board with the governance structure and the hospital management should be described in written documents.

Criteria

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

1.1.1.2 There is an organisational chart or document that describes the lines of authority and accountability between the governance structure and the hospital, as well as within the hospital.

1.1.1.3 Those responsible for governance approve and make public the hospital's mission statement.

1.1.1.4 Those responsible for governance ensure approval of strategic policies and strategic plans to operate the hospital.

1.1.1.5 Those responsible for governance approve the budget and allocate resources required to meet the hospital's mission.

1.1.1.6 Those responsible for governance appoint the hospital's senior manager(s).

1.1.1.7 Those responsible for governance collaborate with the hospital's managers.

1.1.1.8 Those responsible for governance receive and act upon reports of the quality programme, at least quarterly.

1.1.1.9 Those responsible for governance receive and act upon reports on risk management, at least quarterly.

1.1.1.10 Those responsible for governance evaluate the performance of the hospital's senior manager, at least annually.

1.1.1.11 Communication and cooperation between the hospital's governance structure, management and the catchment population is established.

1.1.1.12 The effectiveness and performance of the governance structure is evaluated, at least annually.

1.2 Management of the hospital

1.2.1 *A senior manager is responsible for operating the hospital within applicable Namibian laws and regulations.*

Standard Intent
The senior manager is appointed by the governance structure to be responsible for the overall day-today operation of the hospital. These responsibilities should be documented and known to the personnel of the hospital. The individual appointed to carry out these functions should have the education and experience to do so.
The senior manager is responsible for the implementation of all policies throughout the hospital.

The criteria for this standard are scored according to the survey findings throughout the hospital. The volume and severity of identified deficiencies in related Service Elements will determine whether the criteria are penalised and to what extent.

Criteria

1.2.1.1 The senior manager has the education and experience to match the requirements in the job description.

1.2.1.2 The senior manager manages the day-to-day operation of the hospital, including those responsibilities described in the position description.

1.2.1.3 The senior manager carries out approved policies for management functions.

1.2.1.4 The senior manager monitors compliance with applicable laws and regulations.

1.2.1.5 The senior manager responds to any reports from inspecting and regulatory agencies.

1.2.2 *A senior manager implements processes to manage and control the hospital.*

Standard Intent
The criteria for this standard are scored according to the survey findings throughout the hospital. The volume and severity of identified deficiencies in related Service Elements will determine whether the criteria are penalised and to what extent.

Criteria

1.2.2.1 The senior manager implements processes to manage and control human, financial and other resources.

1.2.2.2 The hospital is licensed in terms of relevant legislation for the level of service provided.

1.2.2.3 The senior manager ensures that the required physical facilities, installations and equipment are available and are used optimally to provide the specified services.

1.2.2.4 There is a documented procedure to guide the delegation of authorities within the hospital.

1.2.2.5 The senior manager ensures the implementation of risk management processes and activities.

1.2.2.6 The senior manager implements processes to monitor patient expectations and satisfaction.

1.2.2.7 The senior manager implements processes to monitor personnel expectations and satisfaction.

1.2.2.8 The senior manager implements processes for quality management and improvement.

1.2.2.9 The senior manager implements processes to monitor the quality of clinical and other services.

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

Standard Intent

A hospital's mission statement usually reflects the needs of its catchment population. Patient care services must be planned and designed to respond to those needs. Referral and specialty hospitals similarly derive their mission from the needs of their catchment population, but this population is usually drawn from a larger geographical area.

While managers are appointed to posts and have a leadership role, leaders in a hospital may arise from many sources. These leaders may represent every service in the hospital, e.g. medical, nursing, maintenance, administration, physiotherapy and radiography. Leaders may also be nominated or elected to certain committees, e.g. health and safety committees and infection control committees.
Effective leadership is essential for a hospital to be able to operate efficiently and fulfil its mission. Leaders may have formal titles or may be recognised for their seniority, stature or contribution to the hospital. It is important that all the leaders of a hospital are acknowledged and brought into the process of defining the hospital's mission.

Patient care services should be planned and designed to respond to the needs of the patient population. Leaders of the various clinical departments and services in the hospital will determine which diagnostic, therapeutic, rehabilitative and other services are essential to the catchment population, as well as the scope and intensity of the services to be provided. In private hospitals, those persons who have an interest or a share in the services should be consulted during the planning processes.

Criteria

1.2.3.1 The leaders of the hospital are formally identified.

1.2.3.2 The leaders of the hospital identify the desired or expected services for their catchment population.

1.2.3.3 The leaders work collaboratively to develop and implement the strategic plan of the hospital.

1.2.3.4 Progress in implementing the plan is monitored at regular intervals according to hospital policy.

1.2.3.5 The hospital's leaders meet with the leaders of other relevant provider organisations in their community to develop and revise strategic and operational plans to meet the needs of the catchment population.

1.2.4 *The hospital communicates with its catchment population to facilitate access to information about its patient care services.*

Standard Intent
Hospitals should define their catchment population and develop and implement information systems to ensure ongoing communication with them. Communication may be directly with individuals, through public media, through agencies within the community or third parties.

Criteria
1.2.4.1 The hospital has identified its catchment population.

1.2.4.2 The hospital has implemented a communication strategy with its catchment population.
1.2.4.3 The services provided by the hospital are made known to the catchment population.
1.2.4.4 The hospital provides information on the quality of its services.

1.2.5 *The hospital provides patient care within ethical and legal norms.*

Standard Intent
A hospital has ethical and legal responsibilities to the patients it serves. The leaders must understand these responsibilities as they apply to the business and clinical activities of the hospital. The leaders should create guiding documents, such as the hospital's mission and values, to provide a consistent framework to carry out those responsibilities. The mission statement should define the overall purpose or main reason for the hospital's presence.

Values should provide hospital personnel with guidance on how they are expected to behave in delivering their services e.g. with courtesy and compassion. (Many hospitals publish their mission and values on the internet which can be consulted for examples if required.) The hospital should establish and implement a framework for ethical management that includes at least marketing, admissions, treatment, withdrawal or withholding of treatment, transfers, discharges, disclosure of ownership and any business or professional conflicts that may not be in patients' best interests.

The hospital should operate within this framework to:
- Disclose ownership and any conflicts of interest
- Honestly portray its services to patients
- Provide clear guidelines for the levels of care and services offered
- Withhold resuscitation or life-sustaining measures
- Accurately bill for its services
- Resolve conflicts when financial incentives and payment arrangements could compromise patientcare

If the hospital conducts clinical research, investigations or trials involving patients, a committee or other mechanism must be established to monitor and control all such activities in the hospital. The hospital should develop policies and procedures to guide the committee in carrying out this responsibility, which should include:
- The review process for all research protocols
- A process to ensure that information provided to potential study participants is comprehensive and understandable
- A process to ensure that ethical approval for the study has been obtained

- A process to weigh the relative risks and benefits to the patients
- Ensuring the confidentiality and security of the research information

Those individuals responsible for the oversight of research at the hospital should be familiar with the content of the Declaration of Helsinki and the International Ethical Guidelines for Biomedical Research Involving Human Subjects. The required policies and procedures should be developed in line with these principles. If the hospital participates in retrospective studies, the principles of the World Medical Association's (WMA) Declaration on Ethical Considerations regarding Health Databases should be upheld.

Policies and procedures related to obtaining informed consent from patients participating in clinical research trials should stipulate that patients must be fully informed of the following aspects of the study:

- Aims of the research
- What they will need to do while participating in the study
- Alternative treatments that may be of benefit to them (i.e. alternative to the intervention under investigation)
- Sources of funding
- Any possible conflicts of interest
- Institutional affiliations of the researcher(s)
- The anticipated benefits and potential risks of the study
- The discomfort it may entail
- The right to abstain from participation in the study and the right to withdraw consent to participate at any time, without any consequences in terms of the care they receive from the hospital

In addition, the hospital leaders responsible for oversight of research at the hospital must ensure that the group conducting the research has obtained sufficient indemnity insurance to allow for adequate compensation of research participants should they suffer an adverse event as a result of their participation in the research study.

The criteria for this standard are scored according to the survey findings throughout the hospital. The volume and severity of identified deficiencies in related Service Elements will determine whether the criteria are penalised and to what extent.

Criteria

1.2.5.1 The hospital's leaders establish ethical and legal norms that protect patients and their rights.

1.2.5.2 The hospital's leaders establish processes to receive and resolve ethical dilemmas within a specified time frame according to hospital policy.

1.2.5.3 The hospital's leaders establish organisational values to guide personnel in the manner in which they should behave when performing their functions.

1.2.5.4 The hospital discloses its ownership.

1.2.5.5 The hospital honestly portrays its services to patients.

1.2.5.6 The hospital provides clear admission, treatment, transfer and discharge policies.

1.2.5.7 The hospital bills accurately for services rendered.

1.2.5.8 The hospital has a mechanism to control all research undertaken within the hospital.

1.2.5.9 Policies and procedures that guide the activities of those responsible for oversight of research in the hospital reflect international best practice and are implemented.

1.2.5.10 Policies and procedures that guide personnel in gaining informed consent for research studies are developed and implemented.

1.2.5.11 The authority responsible for control of research activities ensures that adequate indemnity insurance is available to compensate patients who experience an adverse event caused by participation in research studies conducted at the hospital.

1.2.6 *The hospital's leaders ensure that policies and procedures are implemented to support the activities of the hospital and to guide personnel, patients and visitors.*

Standard Intent

Policies and procedures are formulated at different levels of authority, e.g. national acts and regulations, national health and labour departmental policies, regional policies and hospital policies. The policies or procedures should identify:

- How planning will occur
- The documentation required, e.g. professional guidelines and legislation, order forms, communication forms, etc. for the care team to work effectively
- Special consent considerations
- Monitoring requirements
- Special qualifications or skills of personnel involved in the care process
- Availability and use of resuscitation equipment and medication

Efficient management and implementation of the hospital's policy and procedure framework will be greatly facilitated by the inclusion of the following minimum requirements for each policy and procedure/standard operating procedure/pathway/etc.:

- Title: Each policy should have a name or title for identification and reference. - Identifying number: This is to facilitate indexing, locating the policy when required and communicating about the policy accurately.
- Policy statement: What is to be achieved and why.
- Procedure: How the policy is to be achieved. This is a step-by-step description of what needs to be done (like a recipe – following each step should result in a predictable outcome irrespective of who follows the steps).
- Associated references: This is required when the policy is directly associated with specific laws, regulations or policies or corporate policies and procedures. - Dates: The date of the original policy, the date(s) of any revision(s) and the date of the next planned review.
- Signature: This is the signature of the person identified and authorised by the governing body of the hospital to approve policies and procedures.

Leaders must ensure that all policies and procedures which apply to the hospital are available to personnel, that they are implemented as they relate to various departments, services and functions and that the implementation is monitored.

Leaders should ensure that policies and procedures are available to guide personnel in matters such as allocation, use and care of resources, financial practices, human resource management, complaints management and delegations of authority within the hospital.

This section deals with the central control/management of the master filing system(s) of the hospital policy framework, which can be paper-based or electronic.

This section is the "umbrella" for all aspects relating to policies and procedures that are measured in all Service Elements and therefore the final ratings of these criteria should reflect the aggregated scores obtained from the other Service Elements.

The general approach is that these criteria are scored NC/PC if the findings in the other services reflect critical/very serious/high volume deficiencies.

Criteria

1.2.6.1 The hospital's leaders ensure that policies and procedures guide and support the activities and management of the hospital.

1.2.6.2 Policies and procedures guide the retention and destruction of all hospital documentation, including patient-related information, legal, managerial and research documentation.

1.2.6.3 A designated manager is responsible for compiling and indexing policies and procedures and ensuring their circulation, recall, archiving and review.

1.2.6.4 Policies and procedures are signed by persons authorised to do so.

1.2.6.5 Policies and procedures are compiled into a comprehensive manual(s) or filing system (paper-based and/or electronic) which is indexed and easily accessible to all personnel.

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

1.2.6.7 There is a mechanism to ensure that policies are known and implemented.

1.2.7 *The leaders direct the development and monitor the implementation of contracts/agreements for clinical, non-clinical and managerial services.*

Standard Intent

Hospitals frequently have the option to provide clinical, non-clinical and managerial services directly, or to arrange for such services through referral, consultation, contractual arrangements or other agreements. Such services may include for example radiology services, financial accounting services, equipment management, hotel services, etc.

In all cases, the leaders must supervise such written contracts/agreements to ensure that the services meet patient needs and are monitored as part of the hospital's quality management and improvement activities.

Volunteer services when provided must be managed to ensure safe and effective service delivery, coordinated with other services within the hospital.

The criteria for this standard are scored according to the survey findings throughout the hospital. The volume and severity of identified deficiencies in related Service Elements will determine whether the criteria are penalised and to what extent.

Please note the reference to "clinical" in the above intent as the "outsourcing" of clinical services is an integral part of this section and applies especially to the private sector hospitals. There are sometimes written "service level agreements" between private hospitals and private radiology/laboratory services, but one seldom finds such written agreements/contracts with individual healthcare professionals, in which case this section will be scored PC for the relevant criteria.

Contractual arrangements with private doctors (session holders) in the public sector should also be considered in this section.

Arrangements with agencies for the provision of professional personnel such as locum doctors and nurses are included here.

Criteria

1.2.7.1 Copies of contracts are made available to those who ensure their implementation.

1.2.7.2 Services provided under contracts/agreements meet patient needs.

1.2.7.3 Contracts and other arrangements are monitored as part of the hospital's quality management and improvement programme.

1.2.7.4 There is a mechanism to ensure that all volunteers work under the guidance of suitably qualified personnel in the employ of the hospital.

1.2.7.5 Volunteers sign a memorandum of agreement to abide by the conditions of the hospital.

1.2.7.6 There are documented policies and procedures for the activities of the volunteer service which are implemented.

1.2.7.7 Contract workers, volunteers and independent clinical practitioners are orientated to the hospital, their job responsibilities and their specific assignments.

1.2.7.8 There is a system to ensure that independent clinical practitioners and volunteers undergo an evaluation of their performance each year or more frequently, as defined by hospital or organisational policy.

1.2.7.9 The hospital has a process to ensure that independent clinical practitioners and volunteers providing clinical care have valid credentials.

1.2.8 *The hospital's leaders foster communication between individuals and coordinate services among departments.*

Standard Intent

To coordinate and integrate patient care, the leaders should develop a culture that emphasises cooperation and communication. The leaders should develop formal methods (e.g. standing committees, joint teams) and informal methods (e.g. newsletters, posters) for promoting communication between services and individual personnel members.

Coordination of services comes from an understanding of the mission and services of each department and service, and collaboration in the development of common policies and procedures.

Leaders have a special responsibility to patients and to the hospital. These leaders should:

- Support good communication
- Jointly plan and develop policies that guide the delivery of services
- Monitor the quality of service delivery

The leaders of all services create a suitable, effective organisational structure to carry out those responsibilities. The structure chosen can be highly organised with rules and regulations. In general, the structure(s) chosen is (are):

- Inclusive of all relevant personnel
- Consistent with the ownership, mission and structure of the hospital
- Appropriate for the complexity of the hospital
- Effective in carrying out the responsibilities listed above

The criteria for this standard are scored according to the survey findings throughout the hospital. The volume and severity of identified deficiencies in related Service Elements will determine whether the criteria are penalised and to what extent.

Criteria

1.2.8.1 The hospital's leaders promote communication between departments, services and individual personnel members.

1.2.8.2 Agendas are prepared for meetings and personnel are given timely notification in order to prepare for participation.

1.2.8.3 Minutes of meetings are prepared and circulated to all relevant personnel.

1.2.8.4 There is a mechanism to ensure that key issues arising from meetings of the governance structure and/or the management of the hospital are communicated to and acted upon by personnel.

1.3 Management of departments and services

1.3.1 *Identified departmental or service managers control clinical and managerial activities in each department or service.*

Standard Intent

The clinical care, patient outcomes and overall management of a hospital are only as good as the clinical and managerial activities of each individual department or service.

Good departmental or service performance requires clear leadership from a qualified individual. The qualifications of departmental managers should be appropriate to the department, i.e. suitable paediatric, ICU, operating theatre or information technology qualifications, as applicable. In large departments or services, clinical and administrative leadership may be separate. In such cases, the responsibilities of each role should be defined in writing.

Documents should be prepared by each department to define its goals, identify current and planned services and establish the knowledge, skills and availability of the personnel required to assess and meet patient care needs. The leaders of each department or service should make their human resource and other resource requirements known to the hospital's senior managers. This helps to ensure that adequate personnel, space, equipment and other resources are available to meet patient needs at all times. The hospital's management should provide departmental and service managers with the data and information required to manage and improve care and services. Specialised patient care must not be provided in the absence of resources such as skilled and competent personnel or specialised equipment and/or facilities.

Clinical services provided should be coordinated and integrated within each department or service. For example, there should be integration of medical and nursing services. Additionally, each department or service should strive to coordinate and integrate its services with other departments and services. The organisational chart should guide departmental/service personnel in adhering to correct lines of communication. Each department or service should document the lines of communication within that department or service. Unnecessary duplication of services should be avoided or eliminated to conserve resources and ensure efficient, cost-effective service delivery.

The criteria for this standard are scored according to the survey findings throughout the hospital. The volume and severity of identified deficiencies in related Service Elements will determine whether the criteria are penalised and to what extent.

Criteria

1.3.1.1 The hospital ensures that a qualified and/or experienced individual manages each department or service in the hospital.

1.3.1.2 The responsibilities of each departmental manager are defined in writing.

1.3.1.3 The departmental or service manager implements processes to manage and control human, financial and other resources.

1.3.1.4 The departmental or service manager ensures that there are sufficient personnel to provide the services.

1.3.1.5 The departmental or service manager ensures that resources are available to provide those services.

1.3.1.6 Departmental or service managers provide orientation and training for all personnel of the department or service, appropriate to their responsibilities.

1.3.1.7 There is coordination and integration of services with other departments and services.

1.3.1.8 Departmental managers implement quality control and improvement systems.

1.3.2 *Policies and procedures and applicable Namibian laws and regulations guide the uniform care of all patients.*

Standard Intent

As patients move through a hospital from entry to discharge or transfer, several departments and services as well as many different healthcare providers may be involved in providing care. Throughout all phases of care, patient needs should be matched with the appropriate resources within and, when necessary, outside the hospital. This is commonly accomplished by using established criteria or policies that determine the appropriateness of transfers within the hospital.

In order to provide integrated patient care, the hospital needs to design and implement processes for continuity and coordination of care among physicians, nurses and other care providers in:

- Emergency services and inpatient admission
- Diagnostic and treatment services
- Surgical and non-surgical services
- The hospital and other referral services

Leaders of the various care settings and services should work together to design and implement the processes. The processes may be supported by explicit transfer criteria or by policies, procedures or guidelines. The hospital should identify individuals responsible for coordinating patient care (e.g. between departments) or for coordinating the care of individual patients (e.g. the case manager).

Patients with the same health problems and care needs have a right to receive the same quality of care throughout the hospital. To carry out the principle "one level of quality of care" requires clinical and managerial leaders to plan and coordinate the care provided to patients. In particular, services provided to similar patient populations in multiple departments or care settings should be guided by policies and procedures that result in uniform delivery of care in every setting. These policies and procedures should reflect applicable laws and regulations that shape the care process and are best developed collaboratively.

Uniform patient care is reflected in the following:

- Access to and appropriateness of care and treatment should not depend on the patient's ability to pay or on the source of payment
- The seriousness of the patient's condition should determine the resources allocated to meet the patient's needs
- The level of care provided to patients (for example anaesthetic care) should be the same throughout the hospital
- Patients with the same nursing care needs should receive comparable levels of nursing care throughout the hospital

Uniform patient care should result in the efficient use of resources and will permit the evaluation of outcomes of similar care processes throughout the hospital.

The criteria for this standard are scored according to the survey findings throughout the hospital. The volume and severity of identified deficiencies in related Service Elements will determine whether the criteria are penalised and to what extent.

Criteria

1.3.2.1 Care planning and delivery is integrated and coordinated among care settings, departments and services.

1.3.2.2 Clinical practice guidelines relevant to the patients and services of the hospital are implemented to guide uniform patient care processes.

1.3.2.3 The hospital maintains a clinical record for each patient.

1.3.2.4 The patients' clinical records are completed according to guidelines determined by the hospital.

2 Human Resource Management

OVERVIEW OF HUMAN RESOURCE MANAGEMENT

A hospital needs an appropriate number of suitably qualified people to fulfil its mission and meet patient needs. The hospital's clinical and administrative leaders should work together to identify the number and types of personnel needed, based on recommendations from departmental managers.

Recruitment, selection and appointment of personnel are best accomplished through a coordinated, efficient and uniform process. It is essential to document an applicant's skills, knowledge, education and previous work experience. It is particularly important to review the credentials of medical and nursing personnel carefully, because they are involved in clinical care processes and work directly with patients.

Hospitals should provide their personnel with opportunities to grow and advance personally and professionally. This can be achieved by providing in-service training and other developmental opportunities.

2.1 Human resource management support

2.1.1 *Administrative support is provided for the hospital's human resource strategy in order for it to meet the need for an adequate number of suitably qualified and trained personnel.*

Standard Intent

A designated individual should ensure that administrative support personnel provide systems which enable implementation of the human resource strategy. This includes the collection, collation and analysis of data to provide and maintain an effective staffing structure.

Policies and procedures which guide administrative support personnel in all matters relating to human resource management should be available, e.g. Appointments, resignations and termination of service

- Granting of leave and maintenance of leave records
- Payment of salaries
- Payment of pension benefits
- Storage, confidentiality and maintenance of personnel records

Criteria

2.1.1.1 A designated individual is responsible for providing support for the hospital's human resource strategy.

2.1.1.2 The human resource manager is suitably qualified and experienced in human resource management.

2.1.1.3 The human resource manager ensures that policies and procedures are available to guide personnel and that they are implemented.

2.1.1.4 The responsibilities of the human resource manager include ensuring compliance with labour legislation and regulations.

2.1.1.5 The human resource manager uses information on staffing needs provided by clinical and managerial personnel to ensure adequate provision of personnel for service delivery.

2.1.1.6 Details of the hospital's absenteeism, sickness rates and personnel turnover rates are recorded, analysed and presented to senior management to inform relevant decision-making processes.

2.1.1.7 Details of the personnel establishment are recorded and analysed to allow for informed decision making by the hospital's management.

2.1.1.8 Receptionists, telephonists, clerical support personnel and porters are allocated to wards and departments in accordance with service delivery requirements.

2.1.2 *A personnel file is maintained for each employee.*

Standard Intent
Each employee in the hospital should have an up-to-date personnel file which contains information regarding his or her qualifications, results of evaluations and work history. These files should be standardised and monitored to ensure completeness and be kept current.

Personnel records should be stored safely, i.e. protected from theft, damage and misuse. The confidentiality of personnel records must be protected at all times, i.e. when they are in the record storage area and when they are transported elsewhere in the hospital.

Criteria

2.1.2.1 A designated personnel member is responsible for the storage and retrieval of personnel files.

2.1.2.2 Only authorised persons have access to personnel files.

2.1.2.3 Personnel files contain the personal information of the personnel member.

2.1.2.4 Personnel files contain the work history of the personnel member.

2.1.2.5 Personnel files contain job descriptions which include scope of practice.

2.1.2.6 Personnel files contain the qualifications of the personnel member.

2.1.2.7 Personnel files contain copies of any required registration certificate(s).

2.1.2.8 Personnel files contain details of personnel evaluations, which are conducted at least annually or more frequently according to hospital policy.

2.1.2.9 Personnel files are standardised.

2.1.2.10 Personnel files are reviewed at least annually.

2.2 Personnel planning

2.2.1 *The hospital's leaders plan for the provision of adequate numbers of suitably qualified personnel.*

Standard Intent
Appropriate and adequate staffing is critical to patient care. Personnel planning should be conducted by the hospital's clinical and managerial leaders using recognised methods for determining staffing

levels, including professional practice recommendations where available. For example, in calculating the personnel complement required in a ten-bed paediatric intensive care unit, a patient acuity system can be used to determine the number of registered nurses with paediatric intensive care experience required to provide adequate clinical care.

The hospital's mission, mix of patients, workload, services provided, and technology used must be taken into consideration as part of the planning process. Applicable Namibian laws and regulations must be incorporated into the planning.

Personnel retention, rather than recruitment, provides greater long-term benefit. Retention can be improved when leaders support personal development for individual personnel members. Therefore, leaders should collaborate to plan and implement uniform systems and processes related to the recruitment, retention and development of all personnel.

The hospital must have a documented staffing plan which identifies the numbers and types of personnel required and the skills, knowledge and other competencies needed in each department and service. Staffing numbers and the mix of personnel in the hospital must be appropriate for the level of care and type of services provided and must comply with relevant laws and regulations in this regard.
The mission of the hospital and the needs of patients are also central to personnel planning.

The plan must address:

- The reassignment of personnel from one department or service to another in response to changing patient needs or personnel shortages
- The consideration of personnel requests for reassignment, including requests based on cultural values or religious beliefs
- The policies and procedures for transferring responsibility from one individual to another (for example, from a physician to a nurse) when the responsibility falls outside such an individual's usual area of responsibility

Planned and actual staffing levels must be monitored on an ongoing basis and the staffing plan updated as necessary. When monitored at a departmental or service level, there must be a collaborative process for the clinical and managerial leaders of the hospital to update the overall plan.

Criteria

2.2.1.1 There are documented processes for staffing the hospital.

2.2.1.2 The processes include personnel recruitment.

2.2.1.3 The processes include the numbers and categories of personnel required.

2.2.1.4 The processes include the selection and documentation of desired education, qualifications, experience, skills and knowledge for each personnel member to be recruited.

2.2.1.5 The processes include assignment and reassignment of personnel.

2.2.1.6 The processes include personal development of personnel.

2.2.1.7 The processes include measures to improve personnel retention.

2.2.1.8 The processes include succession planning.

2.3 Personnel management

2.3.1 *Each personnel member's responsibilities are defined in a current job description.*

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

Criteria

2.3.1.1 Personnel employed by the hospital have documented job descriptions which define their roles and responsibilities.

2.3.1.2 Job descriptions are reviewed according to hospital policy.

2.3.1.3 Each personnel member signs their job description to indicate their agreement with the contents of the document.

2.3.2 *The hospital uses a defined process to evaluate the knowledge and skills of personnel to ensure that these are aligned with patient needs.*

Standard Intent
The hospital must comply with Namibian laws and regulations that define the educational level, skill or other competencies required for particular personnel members.

The hospital must define the process for and the frequency of the ongoing evaluation of personnel abilities. Where relevant, training must be provided to address any identified deficiencies. While such evaluation is best carried out in an ongoing manner, there must be at least one documented evaluation each year for each personnel member.

When personnel are expected to assume new or changed responsibilities, training must be provided to enable them to do so.

All personnel involved in the clinical care of patients, i.e. doctors, nurses, clinical and therapeutic support services, must participate actively in the hospital's efforts to evaluate their individual performance and clinical care outcomes. Should there be any question about the performance of any individual personnel member at any point, the hospital must have a process in place to evaluate that individual's performance.

Criteria

2.3.2.1 Key performance areas for each personnel member are identified in their job descriptions.

2.3.2.2 The performance of individual personnel members is reviewed when indicated by the findings of quality improvement activities.

2.3.2.3 There is at least one documented evaluation of each personnel member each year or more frequently as defined by hospital policy.

2.3.2.4 New personnel members are evaluated as defined by hospital policy.

2.3.3 *Sound industrial relations based on current labour legislation are implemented and maintained in the hospital.*

Standard Intent
The consistent application of fair labour practices, grievance and disciplinary procedures and dismissal, demotion and retrenchment policies and procedures is essential to prevent labour unrest with its consequent negative impact on patient care. Membership of trade unions and/or health professional organisations should be encouraged and there must be negotiation and consultation between these bodies, the management of the hospital and personnel to promote harmonious working relationships. Current employment policies need to be available, known to relevant personnel and implemented.
Hospital leaders therefore have a responsibility to:

- Be conversant with all current labour Namibian laws and regulations
- Educate personnel managers in relevant aspects of labour law
- Ensure that policies and procedures are developed
- Ensure that these policies and procedures are effectively implemented

Criteria

2.3.3.1 There are mutually agreed processes for the satisfactory conduct of industrial relations activities, which meet the requirements of current legislation.

2.3.3.2 There are recognition agreements with trade unions and/or health professional organisations, where applicable.

2.3.3.3 Disciplinary procedures are implemented.

2.3.3.4 Grievance procedures are implemented.

2.3.3.5 Dispute and appeal procedures are implemented.

2.4 Personnel orientation, induction and education

2.4.1 *All personnel members are orientated to the hospital and to their specific job responsibilities at the time of appointment.*

Standard Intent
The decision to appoint an individual to a position within a hospital sets several processes in motion. To perform well, a new personnel member needs to understand the functioning of the entire hospital and how his or her specific role and responsibilities contribute to the hospital's mission. This is accomplished through a general orientation to the hospital and his or her role in the hospital and a specific orientation to the responsibilities of his or her position. The orientation process should include for example the reporting of medical errors, infection control practices, the hospital's policies on telephonic medication orders, etc. as appropriate for each job role. Contract workers and volunteers should also be orientated to the hospital in relation to their specific assignment or responsibilities, e.g. patient safety when infrastructural changes are made and infection control processes relevant to the service provided by the contractor.

Criteria

2.4.1.1 There are documented programmes for personnel orientation and induction to the hospital.

2.4.1.2 New personnel members are orientated to the hospital within a time frame determined by hospital policy.

2.4.1.3 Departmental and service managers implement orientation programmes for departmental and service personnel.

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

Standard Intent

The hospital has a responsibility to ensure that personnel members are educated in matters which affect their functioning in the hospital. In particular, personnel must be trained in health and safety matters, risk management processes, infection control practices and cardio-pulmonary resuscitation (CPR). The hospital should collect and integrate data from several sources to understand the ongoing educational needs of personnel. Such sources could include: monitoring data from the hospital management programme, the introduction of new technology, deficiencies in skills and knowledge identified through the performance evaluation and review process, new clinical procedures and future plans and development strategies of the hospital.

Education should be relevant to each personnel member as well as to the continuing advancement of the hospital in meeting patient needs and maintaining acceptable personnel performance, teaching new skills and providing training on new equipment and procedures. Where relevant, documented evidence should be available to demonstrate that personnel who have attended training have acquired the necessary competencies, e.g., CPR training and training in the use of newly-acquired medical equipment.

Each department or service manager must ensure that in-service training is provided to personnel in their particular department or service. For example, medical personnel may receive education on advances in medical practice or new technology. Information management personnel may be provided with in-service training on computer software and technicians may receive in-service training on equipment repair.

The leaders of the hospital should support the commitment to ongoing in-service education for personnel by making space, equipment and time available for education and training programmes. Education and training can take place in a centralised location or in several smaller learning and skills development locations throughout the hospital. Education sessions may be offered once to all, or repeated for all personnel on a shift-by-shift basis to minimise the impact on patient care activities.

Criteria

2.4.2.1 The hospital has a coordinated plan for in-service training and development which is implemented.

2.4.2.2 Department and service managers have established in-service training/education programmes relevant to departmental and service personnel.

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

2.4.2.4 Records of in-service training are kept for each personnel member.

2.4.2.5 Personnel competencies are assessed and recorded after in-service training according to hospital policy.

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

Standard Intent

The hospital must have a process for informing personnel of opportunities for continuing education and training, participation in research and investigational studies and acquiring new or advanced skills. These opportunities may be offered by the hospital, by professional or trade associations or by educational programmes in the community. The hospital should support educational opportunities appropriate to its mission and resources. Such support may be given through scheduled time away from work, tuition support, recognition of achievement, or in other ways.

Criteria

2.4.3.1 There is a development strategy for the hospital which ensures that managers receive the training required to fulfil their responsibilities.

2.4.3.2 There is a training strategy for the hospital which ensures that all personnel update their knowledge and skills regularly.

2.4.3.3 Personnel are informed of opportunities to participate in advanced education, ongoing training and research, and acquire postgraduate qualifications relevant to the services provided by the hospital.

2.4.3.4 The hospital supports personnel participation in such opportunities.

2.5 Verification of personnel credentials

2.5.1 *The hospital has an effective process for gathering, verifying and evaluating the credentials (registration, education, training and experience) of those healthcare professionals who are permitted to provide patient care.*

Standard Intent

Healthcare professionals registered to provide patient care, with or without clinical supervision, are primarily responsible for patient care and outcomes. These professionals usually include doctors, dentists, professional nurses, pharmacists, radiographers and therapeutic support personnel.

The hospital should identify those individuals permitted to work independently in compliance with Namibian applicable laws and regulations. The hospital is responsible for ensuring that these individuals are qualified to provide patient care without clinical supervision and for specifying the types of care they are permitted to provide within the hospital. The hospital should ensure that the complement of qualified health professionals appropriately matches its mission, resources and patient needs. To ensure such a match, the hospital must evaluate personnel members' credentials at the time of their appointment. These credentials should include documented evidence of completion of appropriate professional education, current registration and any additional training and experience. The hospital should develop a process to gather this information, verify its accuracy where possible and evaluate it in relation to the needs of the hospital and its patients. This process can be conducted by the hospital or by an external agency such as a ministry of health in the case of public hospitals. The process should apply to all types and levels of healthcare workers (employed, honorary, contract and private practitioners).

Evaluating an individual's credentials is the basis for two decisions: whether this individual can contribute to fulfilling the hospital's mission and meeting patient needs and if so, what clinical services this individual is qualified to perform. These two decisions must be documented and the latter decision provides the basis for ongoing evaluation of the individual's performance.

Criteria

2.5.1.1 Those permitted to provide patient care without supervision are identified.

2.5.1.2 The registration, education, training and experience of all healthcare professionals is verified from the original sources where possible.

2.5.1.3 The services to be provided by each personnel member are made known to appropriate individuals and units within the hospital.

2.6 Quality improvement

2.6.1 *A formalised, proactive quality improvement approach is maintained in the service.*

Standard Intent

This refers to the implementation of the hospital quality improvement process (Service Element 7). The senior management team is responsible for ensuring that standards are set throughout the hospital. Within each department or service, unit managers must ensure that standards are set for the particular unit. Departmental or service managers must use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structure(s) to ensure coordinated quality improvement activities throughout the hospital.

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service, for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a software programme will be scored NC.

Criteria

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

2.6.1.2 Indicators of performance are identified to evaluate the quality of the service.

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

2.7 Risk management

2.7.1 *The department/service implements risk management processes.*

Standard Intent

This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

2.7.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of the hospital's risk management processes.

2.7.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

2.7.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

2.7.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

2.7.1.5 Fire safety measures are implemented.

2.7.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

3 Administrative Support

OVERVIEW OF ADMINISTRATIVE SUPPORT

The administrative support service should provide the hospital with effective structures to support patient care. Hospital leaders need to be able to rely on an effective and efficient administrative support system for the planning, organisation and coordination of managerial processes. Personnel responsible for providing administrative support services must be suitably trained and experienced in their respective areas of responsibility, e.g. financial management, supply chain management and information technology (IT) equipment management.

The administrative service is frequently the window to the public, e.g. admission and discharge systems and sending and collecting accounts. It is therefore a key service in terms of patient experience and consequently patient satisfaction.

The administrative support system should ensure an effective filing and storage system for all records, including financial, personnel and patient records.

Administrative personnel should be able to provide documented evidence of the implementation of quality improvement methods in the ongoing monitoring and evaluation of administrative support structures.

Standards

3.1 Financial management

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

Standard Intent

Financial planning and management should be conducted by a person who is suitably qualified and experienced in all matters relating to the hospital's finances.

The financial manager should ensure that policies and procedures are available to guide personnel in the execution of their duties. These policies and procedures should be aligned with national and local legislation and regulations and should include as a minimum:

a) Accounting functions
b) Internal audit system
c) Payment of creditors
d) Acquisition of assets (this policy should include the selection and prioritisation of assets to be acquired and should specify that both users and the persons responsible for medical equipment management should be consulted in the determination of asset specifications)
e) Effective filing system for financial records

Departmental leaders should be included in the budget planning process for their departments. Departmental information relating to available funds and up-to-date statements of current expenditure should be made available to the managers of each department. Sound accounting and auditing practices should be implemented to ensure transparency.

Financial managers should be able to demonstrate improvements in their services through the implementation of quality improvement methods.

Criteria

3.1.1.1 A designated financial manager is responsible for the implementation and maintenance of the financial strategy.

3.1.1.2 The financial manager ensures that policies and procedures and/or directives, which include (a)-(e) in the standard intent above as a minimum, are available to guide personnel and that they are implemented.

3.1.1.3 There is a mechanism for allowing personnel to participate in the development and management of budgets.

3.1.1.4 A monthly report is produced for the senior management team, setting out the financial position to date.

3.1.1.5 There is a mechanism for establishing the reason for budget variation in either income or expenditure.

3.1.1.6 Annual financial statements are produced at the end of each financial year.

3.1.1.7 Internal and external audit reports and responses thereto are available.

3.1.1.8 There is a capital asset register, which is routinely maintained.

3.1.1.9 There is a capital asset replacement programme.

3.1.1.10 When the acquisition of new assets is agreed, required asset specifications are defined in collaboration with users and those responsible for medical equipment maintenance.

3.1.1.11 There is a mechanism to ensure that the level of debtors is kept to a minimum.

3.2 Supply chain management

3.2.1 *There is a system to ensure that equipment and supplies are ordered, available, stored and distributed from a designated point.*

Standard Intent

A designated individual with the relevant training and experience should be responsible for supply chain management. This includes timely ordering of equipment and supplies, the quality assurance check of delivered goods, safe storage, prevention and notification of losses, effective distribution to departments on request and maintenance of information relating to ordering, receipt, storage and distribution of equipment and supplies. Managers should be confident that all equipment and supplies required by their departments will be available immediately on request.

Policies and procedures should be available to guide the processes of supply chain management, including as a minimum:

a) Selection of medical supplies and consumables
b) Ordering of and payment for supplies and equipment
c) How to order supplies based on past consumption
d) Quality assurance processes for goods received
e) Safe storage of supplies
f) Condemning procedures for equipment and supplies
g) The security of order books, prescription pads and other face-value documents

In particular, the policies and procedures relating to the selection of medical supplies and consumables must require that the end users of these products are involved in the selection process. This is to ensure that products selected are suitable for use with existing equipment and appropriate for the services provided, thereby avoiding the potential waste of scarce resources.

Hospital leaders should ensure that finances are made available for the purchase of equipment and supplies required for service delivery, as identified by departmental managers. Procurement managers therefore need to work closely with the financial manager.
The high costs of hospital supplies and equipment make it essential that sound auditing practices are in place to ensure control of the financial aspects of supply chain management. A management information system must track all inventory. Expenditure on equipment and supplies must be transparent. All records must be monitored and available to managers and auditors for accounting.

Criteria

3.2.1.1 A designated individual is responsible for the ordering, storage, distribution and control of equipment and supplies used in the hospital.

3.2.1.2 The supply chain manager ensures that policies and procedures and/or directives, including (a)-(g) in the standard intent above as a minimum, are available to guide personnel and that they are implemented.

3.2.1.3 All losses are reported, recorded and investigated and appropriate action taken to prevent recurrence.

3.2.1.4 There is an inventory of all goods stored.

3.2.2 *All equipment and supplies are safely stored.*

Standard Intent
The storage of equipment and supplies must allow for security, ease of access and effective inventory taking. Acts and regulations, as well as policies and procedures, should be used to guide the storage of equipment and supplies.

The supply chain management service should ensure that supplies and provisions are ordered, received and distributed to departments in time to meet their needs.

This standard is scored NA if the physical facility (central main store) does not exist, e.g., in small hospitals or private hospitals where ordered items are delivered directly to the ward or department. Please note that 3.2.2.6 (storage of hazardous and flammable materials) applies to this central store ONLY.

Criteria

3.2.2.1 Secure storage facilities with controlled access are available.

3.2.2.2 Separate designated storage areas for receiving and unpacking incoming goods are provided.

3.2.2.3 A record is kept of goods received and goods issued.

3.2.2.4 Records are audited.

3.2.2.5 There is adequate space to allow for orderly storage of goods which enables the safe retrieval of equipment and supplies.

3.2.2.6 Hazardous and flammable materials are stored in accordance with relevant regulations.

3.2.2.7 Goods are stored in accordance with the temperature requirements specified by the manufacturer.

3.2.2.8 Walk-in refrigerators and cool rooms can be opened from the inside using a safety release mechanism.

3.3 Health record management

3.3.1 *There is a system for the management of health records, which meets confidentiality and safety requirements.*

Standard Intent

The requirements set out in this standard apply to both paper-based and electronic health record systems. Electronic systems vary greatly in their sophistication and can range from a simple spreadsheet which registers all patient admissions/folders to an entire health record.

A designated individual with relevant training and/or experience should be responsible for health record management. This individual is responsible for the safe, secure storage and retrieval of health records. Safety of health records is ensured by protecting them from electronic failure, fire, flood or other damage. Security of the records is ensured by protecting them from theft, tampering and breach of confidentiality. Health records must be readily available each time the patient visits a healthcare professional and therefore must be filed in such a way that they are easily located and misfiling is readily apparent. Policies and procedures to cover the following aspects of health record management should be developed and implemented, including as a minimum:

a) Creation of patient records (including actions to be taken when a previously created patient record cannot be found)
b) Safety of patient records
c) Security of patient records
d) Confidentiality of patient records
e) Handling and filing of patient information
f) Filing, retrieval and distribution of patient records (including how records will be tracked, traced and returned once issued; and the requirements for records which need to be stored separately, e.g.
g) occupational health records, road traffic accident records, records for specific clinics or clinical conditions, etc.)
h) Storage of records outside the central record store or archive
i) Retention periods
j) Archiving of medical records, including policies and procedures relating to the archiving of medical records with a contracted service provider
k) Destruction of records, including who is responsible for authorising the destruction of health records
l) Patient access to their own health information
m) Release of patient information to a third party

Policies and procedures relating to the confidentiality of health records and retention periods should be developed in accordance with Namibian legislation. Certain types of records may have legally specified retention periods, e.g. records relating to occupational health, paediatric care, medico-legal cases or road traffic accidents. The retention policy and procedure should identify all such records and specify the retention period for each type of record. Where discretion is allowed for retention periods, the retention period selected should be sufficient to support continuity of patient care. The retention and destruction policies should ensure that the confidentiality and security of such information is maintained during these processes.

Hospitals often do not have a single, central location from where records are managed and it is important to ensure that these standards and criteria are met and maintained in ALL areas where health records are handled, stored or archived.

Where archiving of health records has been outsourced, the assessment will not include the warehouses of these private companies. However, the ability of the contracted service provider to meet safety, security and confidentiality requirements as specified above should be assessed during the tender process. Documented evidence should be available to confirm that the arrangements are adequate. (Refer to criteria 1.2.7.1 and 1.2.7.3.)

Useful guidance on health record management has been developed by the World Health Organisation (WHO).
Appropriate quality management systems must be implemented in the medical records department. These systems should ensure that the service monitors its performance and addresses any improvements required in order to provide an effective and efficient service to support patient care within the hospital.
The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring new storage cabinets will be scored NC.

Criteria

3.3.1.1 A designated individual with appropriate training and/or experience is responsible for the storage, maintenance and retrieval of health records.

3.3.1.2 The health record manager ensures that policies and procedures, including (a)-(l) in the standard intent above as a minimum, are available to guide personnel and that they are implemented.

3.3.1.3 All patient documents, including medical, nursing and other health professional notes, diagnostic test results, referral letters, etc. are filed in the correct record, chronologically and in a standardised manner.

3.3.1.4 There is a system that allows for the rapid retrieval and distribution of health records.

3.3.1.5 There is a communication system for the requesting of health records.

3.3.1.6 There is an effective monitoring system whereby records can be traced within the facility at all times.

3.3.1.7 The filing system allows for incorrectly filed records to be easily identified.

3.3.1.8 There is provision for authorised access to health records at all times.

3.3.1.9 All storage areas for health records are secured against unauthorised entry.

3.3.1.10 Quality management processes are designed and implemented.

3.4 Information Technology equipment management

3.4.1 *Where Information Technology equipment is available, it is properly maintained to meet the needs of the services.*

Standard Intent

Hospitals have a responsibility to ensure that appropriate Information Technology (IT) equipment, e.g. computers, printers, wireless routers, ADSL lines, etc., is available and ready for use at all times. There should be a systematic approach to ensuring that cost-effective, safe and appropriate IT equipment is available to meet hospital demands. The management of the department should include appropriate accountability structures.

Managers are responsible for ensuring that IT equipment is available, appropriately maintained and calibrated and that personnel are competent in the use thereof. Policies and procedures to guide personnel in the back-up of electronically stored data should be available. Appropriate quality management systems must be implemented in the IT equipment management service. These systems should ensure that the service monitors its performance and addresses any improvements required in order to provide an effective and efficient service to support patient care within the hospital.

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

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

Criteria

3.4.1.1 A designated individual supervises the management of IT equipment in the organisation.

3.4.1.2 Technical IT support is provided in the hospital.

3.4.1.3 Clinical and managerial personnel participate in IT decisions.

3.4.1.4 Policies and procedures that guide the management of IT equipment are implemented.

3.4.1.5 All server computers are attached to an uninterrupted power supply (UPS) with surge protection.

3.4.1.6 Records are kept of the maintenance of IT equipment.

3.4.1.7 There is a documented procedure known to personnel for reporting defects in IT equipment during and after normal working hours.

3.4.1.8 Quality management processes are designed and implemented.

3.5 Use of Motor Vehicles

3.5.1 *The use of organisational motor vehicles by personnel is planned and monitored to ensure safety and legality.*

Standard Intent

The use of vehicles needs to be controlled because of the cost of acquiring and maintaining vehicles and the legal requirements for driving motor vehicles and transporting passengers. This standard applies to the vehicles used for transporting non-acute patients between facilities, e.g., for out-patient appointments, personnel use of vehicles in the course of their duties and the transport of goods, supplies and other items between facilities.

Appropriate quality management systems must be implemented in the motor vehicle management service. These systems should ensure that the service monitors its performance and addresses any improvements required in order to provide an effective and efficient service to support patient care within the hospital.

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a vehicle will be scored NC.

Criteria

3.5.1.1 A specific manager is identified for the control, use and maintenance of vehicles.

3.5.1.2 The ability of the transport service to meet the transport needs of the departments/services is evaluated on an annual basis and appropriate action taken when necessary.

3.5.1.3 There is a system for monitoring the use of vehicles.

3.5.1.4 There is a system for booking vehicles in advance.

3.5.1.5 There is a control system for mileage travelled.

3.5.1.6 There is a vehicle maintenance plan.

3.5.1.7 There is proof of vehicle maintenance.

3.5.1.8 There is proof of current licensing of vehicles.

3.5.1.9 Drivers of vehicles are suitably licensed.

3.5.1.10 Drivers of vehicles are suitably insured.

3.5.1.11 Quality management processes are designed and implemented.

3.6 Risk management

3.6.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of organisational risk management processes (Service Element 5). This standard applies to each of the different services included in this Service Element.

Criteria

3.6.1.1 The departmental heads conduct ongoing monitoring of risks through documented assessments as part of organisational risk management processes.

3.6.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

3.6.1.3 Aids are available for manual handling of heavy goods.

3.6.1.4 Ladders are available where required.

3.6.1.5 Security measures are implemented to ensure the safety of patients, personnel and visitors.

3.6.1.6 Fire safety measures are implemented.

3.6.1.7 The organisation's policy on handling, storage and disposal of healthcare waste is implemented.

4 Access to Care and Patient Rights

OVERVIEW OF ACCESS TO CARE AND PATIENT RIGHTS

A hospital should consider the care it provides as part of an integrated system of services, healthcare professionals and levels of care, which together make up a continuum of care. The goal is to match the patient's healthcare needs correctly to the services available, coordinate the services provided to the patient in the hospital, and plan for discharge and follow-up. The result is improved patient outcomes and more efficient use of available resources.

Information is essential for making correct decisions about:

- Which patient needs can be met by the hospital
- The efficient flow of services to the patient
- The appropriate transfer or discharge of the patient to his or her home or another care setting

In order to meet the catchment population's needs for services, the hospital must clearly define the boundaries of the catchment population, the boundaries of the services provided by the hospital and involve the catchment population in the planning for care. The catchment population should be provided with information relating to the services offered by the hospital, the hours at which services are provided and how to access these services.

Each patient is unique, with his or her own needs, values, culture and beliefs. Hospitals must strive to establish trust and open communication with patients and to understand and protect each patient's cultural, psychosocial and spiritual values. Patient outcomes are improved when patients and their families, or those who make decisions on their behalf (when appropriate), are involved in care decisions and processes in a way that matches social and cultural expectations.

To promote patient rights in a hospital, these rights must first be defined. Patients and personnel should then be educated about these rights. Patients should be informed of their rights and how to act on them. Personnel should be taught to understand and respect patients' beliefs and values and provide considerate and respectful care, thus protecting the patients' dignity.

This Service Element addresses processes to:

- Identify, protect and promote patient rights
- Inform patients of their rights
- Include the patient's family in decisions about the patient's care when appropriate
- Obtain informed consent
- Educate personnel about patient rights
- Guide the hospital's ethical framework

How these processes are carried out within a hospital depends on Namibian laws, regulations and charters and any international conventions, treaties or agreements on human rights endorsed by Namibia. The implementation of patient rights is dependent on the hospital providing equitable services, which means delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location or socio-economic status.

Standards

4.1 Access to care

4.1.1 *The hospital seeks to identify and reduce barriers to access and delivery of services.*

Standard Intent

Access to care is the most fundamental right for potential patients. There are five recognised dimensions to access to healthcare, namely affordability, availability, accessibility, accommodation and acceptability. Affordability refers to the ability and willingness of the patient to pay for the health services

they require. Availability refers to the services offered by the hospital and whether they match the services required by the patient. Accessibility refers to the geographic location of the hospital and physical access to the building. Accommodation refers to the hospital's efforts to accommodate patient preferences. Acceptability refers to the extent to which the patient is comfortable with the characteristics of the hospital, personnel and services.

The application of this framework to a hospital can assist in the identification of barriers to access. The relevant management team (senior management team or specifically-appointed access management team) should then develop strategies to overcome these barriers, thereby improving access to their services for the catchment population.

For example, a patient who feels that their preferences will be ignored by personnel may be reluctant to access services, especially where these preferences represent deeply-held beliefs, e.g., the avoidance of certain foods, the need to perform certain rituals or the preference to receive care from certain types of people. If these preferences are acknowledged and accommodated, patients who hold these beliefs may be more likely to access services when they are needed. As a further example, deeply held beliefs regarding the acceptability of certain treatments, e.g., ingestion of medication containing animal products or receiving a blood transfusion, may discourage patients from accessing care if they fear that their beliefs will be disregarded. As a final example, language barriers, e.g., deaf patients or patients who speak languages that are not understood by healthcare personnel at the hospital, can present a barrier to accessing care. These examples are not an exhaustive list and are highlighted merely to provide guidance on how to approach the identification of barriers in a hospital's catchment population.

Criteria

4.1.1.1 The hospital has identified barriers to accessing healthcare services in its catchment population.

4.1.1.2 There is a process to limit the impact of barriers on access to the services provided by the hospital.

4.1.1.3 The hospital has access to ambulance services appropriate for the level of care provided.

4.1.2 *Structural barriers to access to the hospital are identified and overcome or lessened.*

Standard Intent

The senior management team should identify potential structural barriers to access, e.g., patients with physical disabilities may find it difficult to climb stairs and patients unfamiliar with the area may find it difficult to locate the hospital. Signage to the hospital from access routes, signage within the hospital, safety precautions and assistive devices for patients with decreased mobility can help to overcome these physical barriers to access.

Criteria

4.1.2.1 Directional signage to the hospital is clearly visible from all main access roads.

4.1.2.2 The name of the hospital and the services provided is clearly indicated on the site.

4.1.2.3 Adequate parking is available for patients and visitors, including designated parking provision for disabled patients.

4.1.2.4 Ramps and stairs include safety features such as rails where appropriate.

4.1.2.5 Directional signage within the hospital includes local languages and relevant symbols.

4.1.2.6 The hospital makes assistive mobility devices, e.g. wheelchairs, available for patients who require such assistance during their visit.

4.1.2.7 There is access to and within the building for patients using assistive devices, e.g. wheelchairs, walking frames, etc.

4.1.2.8 Lifts or ramps are available in multi-storey buildings for patients unable to use the stairs.

4.1.3 *Patients are assessed on arrival to ensure their healthcare needs are met efficiently.*

Standard Intent

To improve access to its services, the hospital must provide information to the catchment population on its services, hours of operation and how to obtain care. Personnel must ensure that the healthcare needs of patients received into the hospital will be met by the services they provide. This is achieved by means of a thorough screening assessment to determine the type of preventive, palliative, curative and rehabilitative services needed by the patient. Patients for whom the hospital cannot provide the required care must be referred or redirected to appropriate services.

Patients' needs can be identified by means of a triage process, screening assessment, or medical history and physical examination of the patient. Sometimes this assessment has been performed by another healthcare provider prior to the patient's arrival at the hospital. In these cases, the patient should be directed to the appropriate service according to this assessment, where the patient will then be reassessed.

Patients attending the Accident and Emergency Department should be assessed using an evidence-based triage process to identify those patients requiring immediate or urgent care. For critically ill patients, the admission assessment will be rapid and include concurrent diagnostic testing and treatment. It may also require relevant specialists to be summoned urgently to the patient's location. If the hospital is unable to meet the healthcare needs of emergency patients, they must be stabilised prior to transfer.

Certain patients may require a modified assessment, e.g.

- Children
- Adolescents
- Frail, dependent patients of any age
- Terminally ill/dying patients
- Patients with intense or chronic pain
- Women in labour
- Women requiring termination of pregnancy
- Patients with emotional or psychiatric disorders
- Patients suspected of drug and/or alcohol dependency
- Victims of abuse and neglect
- Patients with infectious or communicable diseases
- Patients receiving chemotherapy or radiation therapy
- Patients whose immune systems are compromised
- Patients with particular cultural requirements, beliefs or value

The hospital should identify which groups of patients accessing their services are likely to require modified assessments and make provision for this in their assessment processes.

Diagnostic testing may also be required to:

- Determine the patient's needs
- Determine if the hospital has the appropriate resources to treat the patient
- Establish if the patient should be referred or transferred to another setting for care Diagnostic test results must be made available to those responsible for deciding on further management in the hospital or whether to transfer or refer the patient. Patients should be informed when there are known long waiting periods for diagnostic and/or treatment services or when obtaining the planned care may require placement on a waiting list. Patients should be informed of the associated reasons for the delay or wait and informed of available alternatives. This requirement applies to inpatient and ambulatory care and/or diagnostic services, not to minor waits in providing outpatient or inpatient care, e.g. when a physician is behind schedule.

Criteria

4.1.3.1 Information on services, hours of operation and processes to obtain care are available to agencies and referral sources in the community and to the catchment population.

4.1.3.2 Assessment is initiated at the point of first contact with the hospital.

4.1.3.3 Patients attending for emergency care are triaged using an evidence-based triage process.

4.1.3.4 Patients identified by triage as having emergency or immediate needs are prioritised for assessment and intervention according to established criteria.

4.1.3.5 Patients are received into the hospital only if the hospital has the ability to provide the necessary services and settings for care.

4.1.3.6 Access to services not offered by the hospital is facilitated by providing patients with information on how to access these services.

4.1.3.7 Emergency patients who require transfer to another hospital for appropriate services are stabilised prior to transfer.

4.1.4 *The hospital has established processes for admitting inpatients and registering ambulatory patients.*

Standard Intent

Ambulatory' refers to patients attending services on an out-patient basis, i.e., they are not formally admitted for care. This includes out-patient care, attendance at accident and emergency services, attendance for diagnostic tests, minor surgical procedures, dental procedures, etc.

The process for receiving patients into the hospital for care must be standardised through the use of policies and procedures and include as a minimum:

a) Ambulatory registration processes
b) In-patient admission processes
c) Admission of emergency patients to in-patient units
d) The holding of patients for observation
e) The management of patients when bed space is not available in the desired service/unit or elsewhere in the hospital
f) Management of the patient's personal possessions
g) The management of patients deceased prior to arrival

Personnel responsible for these processes should be familiar with and follow the standardised procedures. Registration and admission processes should include confirmation of the patient's contact details, including the name and contact details for next of kin.

When the hospital takes responsibility for any or all of the patient's personal possessions brought into the hospital, there should be a process to account for those possessions and ensure that they will not be lost or stolen. The process should include how to manage the possessions of emergency patients, patients unable to make alternative safekeeping arrangements and patients incapable of making decisions regarding their possessions. The hospital should communicate its responsibility, if any, for the patient's possessions to patients and their families.

Criteria

4.1.4.1 Admission and registration processes are standardised throughout the hospital by means of the development and implementation of policies and procedures which include (a)–(g) in the intent statement as a minimum.

4.1.4.2 Policies and procedures for the management of patients deceased prior to arrival are implemented.

4.1.4.3 General consent/acknowledgement of admission requirements is obtained when patients enter the hospital according to hospital policy.

4.1.4.4 Written consent for the taking and/or publishing of photographic images is obtained from personnel, volunteers, patients and visitors prior to such images being taken.

4.1.4.5 Patients receive information on the hospital's level of responsibility for patients' possessions.

4.1.5 *Admission or transfer to units providing intensive or specialised services is determined by established criteria.*

Standard Intent

Units or services that provide intensive care (e.g. post-surgical intensive care and high dependency units) or specialised services (e.g. the care of patients with burns or organ transplant units) are costly and usually have limited space and personnel. Each hospital must establish criteria for identifying those patients who require the level of care provided in such units. Appropriate individuals from the intensive or specialised services must participate in developing these criteria. The criteria should be used to determine direct entry to the unit, e.g. directly from the emergency service. The criteria should also be used to authorise transfer into the unit from within or outside the hospital and in deciding when a patient no longer requires the services of the unit and can be transferred to another level of care.

Criteria

4.1.5.1 The hospital has established entry and/or transfer criteria for its intensive and specialised units.

4.1.5.2 The criteria are physiological where possible and appropriate.

4.1.5.3 Appropriate individuals are involved in developing the criteria.

4.1.5.4 Personnel are educated regarding the application of the criteria.

4.1.5.5 Patients transferred or admitted to intensive and specialised units/services meet the criteria, as documented in the patient's record.

4.1.5.6 Patients who no longer meet the criteria to remain in the unit are transferred or discharged.

4.2 Informing and educating patients to encourage patient participation in care.

4.2.1 *Patients and their families receive sufficient information to make informed decisions regarding their care.*

Standard Intent

During the care process, patients and their families should receive sufficient information to enable them to participate in decisions regarding their care. Information must be provided on their diagnosis, proposed care, expected results of care after results, alternative care options, consequences of refusing care and any expected cost to the patient or family for that care when this is not paid for by a public or private source. Providing this information is essential to the establishment of open and trusting communication between patients, families and the hospital. Information on alternative sources of care and services must be provided when the required care is beyond the hospital's mission and capabilities. Patients and families should understand when they will be given this information, who is responsible for telling them, the type of decisions that must be made about care and how to participate in those decisions. While some patients may not wish to participate personally in the decisions regarding their care, they should still be given the opportunity to do so and/or be able to choose to participate through a family member, friend or surrogate decision-maker.

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

Patients suffering from notifiable diseases, e.g., TB, tetanus or Hepatitis B, may refuse care. In these instances, Namibian legislation may require specific action to be taken in order to manage the risk that such patients pose to themselves and their community. Under such circumstances, hospital policy must ensure that appropriate action is taken in accordance with this legislation to safeguard the patient and their community.

When obtaining informed consent from patients and/or their legal representatives, they must be provided with all information relating to the planned care to enable them to make informed decisions. The consent process should be clearly defined by the hospital in policies and procedures. Relevant laws and regulations must be incorporated into these policies and procedures. Informed consent for care sometimes requires that people other than, or in addition to, the patient are involved in decisions about the patient's care. This is especially true when the patient does not have the mental or physical capacity to make care decisions, when culture or custom designate that others make care decisions, or when the patient is a child. When the patient cannot make decisions regarding his or her care, a surrogate decision-maker must be identified. When someone other than the patient gives consent, this individual's name, contact details and relationship to the patient must be documented in the patient's record. The information given to the patient and/or others in the course of obtaining informed consent must be documented either on the consent form or in the patient record.

Criteria

4.2.1.1 Policies and procedures that guide personnel in relation to informed consent are implemented.

4.2.1.2 Patients and their families/carers/guardians are provided with information on the proposed care and the expected results of care.

4.2.1.3 The information provided includes any expected costs to the patient or family.

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

4.2.1.5 Patients and their families are informed about the consequences of such decisions.

4.2.1.6 The hospital respects the right of patients and families to refuse or discontinue treatment.

4.2.1.7 Legislative requirements are followed when patients with notifiable diseases refuse treatment.

4.2.1.8 Patients and their families/carers/guardians are informed about immunisations appropriate to their age and/or disease groups.

4.2.2 *The hospital respects patients' wishes and preferences to withhold resuscitative services and forgo or withdraw life-sustaining treatment.*

Standard Intent

Decisions about withholding resuscitative services or forgoing or withdrawing life-sustaining treatment are among the most difficult choices facing patients, families, healthcare professionals and hospitals. No single process can anticipate all the situations in which such decisions must be made. For this reason, it is important for the hospital to develop a framework for making these difficult decisions.
Such a framework should:

- Help the hospital identify its position on these issues
- Ensure that the hospital's position conforms to the religious and cultural norms of the catchment population and any legal or regulatory requirements
- Address situations in which these decisions are modified during care
- Guide health professionals through the ethical and legal issues in carrying out such wishes to ensure that the decision-making process related to carrying out the patient's wishes is applied consistently, policies and procedures that provide this framework should be developed using a collaborative process that includes all, or at least as many as possible, of the healthcare professionals and viewpoints that will come to bear on the situation. The policies and procedures must identify lines of accountability and responsibility and how the process will be documented in the patient's record.

Criteria

4.2.2.1 The hospital has identified its position on withholding resuscitative services and forgoing or withdrawing life-sustaining treatments, which conforms to the religious and cultural norms of the catchment population and any legal or regulatory requirements.

4.2.2.2 Policies and procedures that guide the processes for patients to make their decisions known to the hospital and for modifying decisions during the course of care are implemented.

4.2.2.3 Policies and procedures that guide the hospital's response to patient decisions are implemented.

4.2.2.4 The hospital guides health professionals on the ethical and legal issues in carrying out such wishes.

4.2.3 *Health education supports patient and family participation in care decisions and care processes.*

Standard Intent
Every patient should be offered the information and education required to be active participants in maintaining their own health and wellbeing, appropriate to their current health status. Hospitals may choose to appoint an education coordinator, an education committee or service, or simply work with all personnel to provide education in a coordinated manner.

Criteria

4.2.3.1 The hospital plans patient education consistent with its mission, services and patient population.

4.2.3.2 There is an appropriate structure or mechanism for education throughout the hospital.

4.3 Privacy and confidentiality

4.3.1 *The hospital takes measures to protect patient privacy and maintain confidentiality of patient information.*

Standard Intent
The hospital must ensure that the patient's need for privacy is respected, especially when the patient is providing personal information and undergoing clinical examination. Patients may require privacy from other personnel members, other patients and even from family members.
Medical and other health information, when documented and collected in a patient record or other form, is important for understanding the patient and his or her needs and for providing care and services over time. The hospital must respect such information as confidential and implement policies and procedures that protect this information from loss or misuse. Personnel must respect the confidentiality of patient information by not posting information on the patient's door or at the nursing station, not holding patient-related discussions in public places and not leaving patient information where it can be seen by people who are not authorised to have access to such information. The misuse of patient information can result in the patient's loss of dignity, employment, personal security, financial security, social standing and social or personal relationships. Misuse of patient information can be perpetrated by anyone with access to the information, whether or not they are authorised to have access to the information.
Policies and procedures should alert personnel to common situations where confidentiality of patient information can be at risk and describe how personnel can safeguard the information in these situations. The following list of minimum content should be included in the policies and procedures:

a) The safeguarding of patient records, both paper and electronic, during day-to-day use of patient records at the hospital
b) The release of patient information to the patient
c) The release of patient information to third parties such as family or carers
d) The release of patient information to third parties such as lawyers and insurance companies or their agents
e) The use of patient information for research purposes

f) Maintenance of confidentiality for records no longer in use, e.g., deceased patients and archived records
g) The action to be taken in the event of a breach of confidentiality
h) The requirement for annual refresher education of personnel in the content of these policies and procedures

Criteria

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

4.3.1.2 The patient's need for privacy is protected during all examinations, procedures, treatments and care related discussions.

4.3.1.3 Policies and procedures to guide personnel in maintaining confidentiality of patient information, including (a)-(h) in the standard intent above as a minimum, are implemented.

4.4 Safety and security

4.4.1 *Patients are protected from assault and harm.*

Standard Intent

The hospital must take responsibility for protecting patients from physical assault by outsiders, other patients and personnel. This responsibility is particularly relevant to infants and vulnerable children, the elderly and others unable to protect themselves or signal for help. Each hospital must identify its vulnerable patient groups (including comatose patients and patients with mental or emotional disabilities) and establish processes to protect the rights of individuals in those groups. Vulnerable patient groups and the hospital's responsibility towards them may be identified in Namibian laws, charters or regulations.

Such protection should extend beyond physical assault to other areas of safety such as protection from abuse, negligent care, withholding of services or assistance in the event of a fire. The hospital must seek to prevent assault through processes such as investigating individuals in the hospital without identification, monitoring remote or isolated areas of the hospital and responding quickly to those thought to be in danger of assault.

Personnel must understand their responsibilities in these processes.

Criteria

4.4.1.1 The hospital has documented processes to protect patients from assault and harm.

4.4.1.2 Remote or isolated areas of the hospital are monitored.

4.4.1.3 The hospital has processes to protect patients from abuse and negligence, both within the hospital and in the community.

4.5 Complaint management

4.5.1 *The hospital informs patients and families about its process to receive and act on complaints, conflicts and differences of opinion about patient care and the patient's right to participate in these processes.*

Standard Intent
Patients have a right to voice complaints about their care, and to have those complaints reviewed and resolved. Decisions regarding care sometimes present questions, conflicts or other dilemmas for the hospital and the patient, family or other decision-makers. These dilemmas may arise around issues of access, treatment or discharge. They can be especially difficult to resolve when the issue involves, for example, withholding resuscitative services or forgoing or withdrawing life-sustaining treatment.

The hospital must establish processes for seeking resolution to such dilemmas and complaints. The hospital should identify in these policies and procedures:
a) The process to be followed in the reporting, recording, and investigation of and the response to complaints
b) Those who need to be involved in the processes
c) How the patient and family participate
d) The process to report back to the patient and/or the family within an established time frame
e) The process to be followed to address any identified deficiencies in care
f) The review of complaints to identify any common, underlying causes for complaints, or any emerging themes within the complaints

The process for recording complaints should allow for the identification of adverse events, which should then be managed as an adverse event as well as a complaint.

Criteria

4.5.1.1 Policies and procedures relating to the reporting and investigation of complaints, including (a)-(f) in the standard intent above as a minimum, are implemented.

4.5.1.2 The relevant hospital committee monitors adherence to the established time frame and takes appropriate action when required.

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

4.6 Implementation of patient rights

4.6.1 *The hospital is responsible for providing processes that support patient and family rights during care.*

Standard Intent
Hospital leaders are primarily responsible for the way in which the hospital treats its patients. The leaders need to know and understand patient and family rights and their hospital's responsibilities as specified in Namibian laws, charters and regulations. The leaders should then provide direction to ensure that personnel throughout the hospital assume responsibility for protecting these rights. To protect and advance patient rights effectively, the leaders should work collaboratively, seeking to understand their responsibilities in relation to the catchment population served by the hospital. Patient and family rights are a fundamental element of all contacts between the personnel of the hospital and patients, their families and caregivers. It is therefore important that policies and procedures are developed and uniformly implemented throughout the hospital to ensure that all personnel are aware of and respond to patient and family rights issues, including their role in supporting the right of patients, families and caregivers to participate in the care process.
Admission to a hospital can be a frightening and confusing experience for patients, making it difficult for them to understand and act on their rights. The hospital should therefore prepare a written statement of patient and family rights which can be provided to patients when they enter the hospital for care and

be available throughout their stay, e.g. patient rights posters prominently displayed in reception and patient care areas.

The statement must be appropriate to the patient's age, understanding and language. When written communication is not effective or appropriate, the patient and family must be informed of their rights in a manner they can understand. Each patient brings his or her own set of values and beliefs to the care process. These values and beliefs are frequently cultural and religious in origin. Hospitals frequently serve catchment populations which include several cultural and/or religious groups. The senior management team should identify all of these groups, including relevant minority groups, and ensure that personnel are familiar with the practices, values and beliefs of each of these groups. The hospital must develop a set of policies and procedures which contain all the necessary information for personnel to understand patient and family rights relevant to their catchment population, including social, economic, cultural and behavioural factors and make provision to ensure that the needs of all groups represented are met. These documents should include the right to a second opinion without fear of negative consequences from current care providers. These policies and procedures will then provide the framework to support the implementation of patient rights. The hospital must provide education to all personnel about the rights of patients and families. The educational process should recognise that personnel members may hold values and beliefs that are different from the patients under their care. The educational process should include training for each personnel member responsible for patient care in how to identify patient values and beliefs and how to respect those values and beliefs in the care process.

During the process of health care delivery, patients and/or their families may require spiritual support. This is particularly relevant during end-of-life care. The hospital should have procedures in place to meet the needs of patients and their families at these times.

Criteria

4.6.1.1 Patient and family rights are identified and documented in accordance with current relevant legislation.

4.6.1.2 Policies and procedures which guide and support the protection of patient and family rights in the hospital are developed in accordance with ethical and legal norms and implemented.

4.6.1.3 Documented evidence of personnel training in relation to these policies and procedures is available.

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

4.6.1.5 There are processes in place to respond to the patient’s and their family’s social, spiritual and cultural values, beliefs and needs.

5 Risk Management

OVERVIEW OF RISK MANAGEMENT

Hospitals should provide a safe, functional and supportive environment for patients, families, visitors, personnel and volunteers.

To implement an effective risk management strategy, the relevant management team must:

- Identify, evaluate, reduce and control hazards and risks
- Implement actions to prevent accidents and injuries
- Maintain a safe environment

Effective clinical risk management includes the planning, education and monitoring of resources needed to support the clinical services provided in the in-patient, day care, ambulatory care and home care settings safely and effectively. All personnel should be educated on how to identify and reduce risks and how to monitor and report situations that pose a risk. Indicators should be selected to monitor important systems and identify areas where improvements may be required.

Risk management planning should consider the following areas in all settings, when appropriate to the activities of the hospital:

- Patient safety taking into account the WHO Global Patient Safety Initiatives which highlight problematic areas in health care and describe evidence and expert-based consensus solutions to these problems
- Protection of patients from abuse and assault
- Occupational health and safety programmes – the hospital must comply with legislation relating to health and safety and risk management
- Fire safety - property and occupants must be protected from fire and smoke
- Emergency responses to disasters and emergencies must be planned and effective - Hazardous materials - control of the handling, storage and use of flammable and hazardous materials and safe disposal of hazardous waste
- Security - property and occupants are protected from harm and loss

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

Standards

5.1 Risk management

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

Standard Intent

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

Risk management includes:

- Comprehensive risk assessment of the hospital, which includes as a minimum stakeholder risk, reputational risk, compliance with legislation, ethical risk, environmental risk and sustainability of the hospital
- Development and maintenance of a risk register
- Planning all aspects of the risk management processes (financial, physical, environmental, medico-legal, operational, IT, etc.)

- Implementation of risk management processes
- Education of personnel in the risk management policies and procedures of the hospital
- Ensuring personnel are sufficiently trained to perform their functions, including training in relation to legislation, regulations and standards relevant to their role within the hospital (Please note: this includes those responsible for governance)
- Monitoring risk management processes
- Periodic review and revision of the programme
- Ensuring adequate insurance is available, including insurance for research activities, when relevant

A risk register should be developed containing a list of all identified risks within the hospital, the impact and probability of the risk occurring, the person responsible for monitoring the risk and actions taken to reduce or eliminate the risk. This should be considered a living document which should be updated regularly and reviewed whenever changes in the hospital's risk profile occur, e.g. when construction is undertaken, a new service is offered, or new equipment purchased.

Monitoring all aspects of the risk management system will provide valuable data which can be used to improve risk management processes at the hospital and further reduce risks within the hospital. Clinical risk management should include consideration of adverse events, sentinel events and near misses. An adverse event is an incident which resulted in unintended injury or complication, disability at discharge or death of a patient that occurs during the care of the patient, caused by care processes rather than the underlying condition, which can and frequently does adversely affect the health of the patient.
A sentinel event is an unexpected occurrence (i.e. not related to the natural course of the patient's illness or underlying condition) involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of a limb or function. The phrase 'or risk thereof' includes any process variation for which recurrence carries a significant chance of a serious adverse outcome.
A near-miss, or close call is defined as any event or situation that had the potential to cause harm to a patient in the form of an accident, injury or illness but did not, either by chance or through timely intervention.

The senior management team should establish categories for reportable events and definitions for adverse events, near miss events and sentinel events. All relevant personnel should receive training to ensure they understand the categorisation and definition of these incidents and the actions to be taken if and when such incidents occur.

Criteria

5.1.1.1 Hospital-wide risk management systems are developed and implemented.

5.1.1.2 The risk management team develops and maintains a risk register for the hospital.

5.1.1.3 Risk management processes include documented plans and actions to eliminate or reduce the identified risks.

5.1.1.4 Risk management processes include ongoing documented monitoring of risks.

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

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

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

5.1.1.8 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

5.1.1.9 The hospital has a policy for communicating relevant information to patients affected by adverse events and sentinel events, including the outcome of investigations.

5.1.1.10 Analysed data, including near misses, adverse events and sentinel events is used to monitor the effectiveness of the risk management system.

5.1.1.11 Risk management systems are reviewed, and the risk register updated whenever there are changes in hospital systems and processes, or physical facilities.

5.2 Patient safety

5.2.1 *The hospital develops an approach to improve accuracy of patient identification.*

Standard Intent

Errors relating to patient identification occur in virtually all aspects of diagnosis and treatment. Patients may be sedated, disoriented or not fully alert; may change beds, rooms or locations within the hospital; may have sensory disabilities; or may be subject to other situations that may lead to errors in identification. The intent of this standard is twofold: first, to identify with certainty that the individual is the person for whom the service or treatment is intended; second, to match the service or treatment to that individual.

Policies and/or procedures should be developed collaboratively to improve identification processes, in particular, the processes used to identify a patient when administering medications, blood, or blood products; taking blood and other specimens for clinical testing; or providing any other treatments or procedures. The policies and/or procedures should specify the use of at least two patient identifiers unique to the patient, such as the patient's name, identification number, date of birth, bar-coded wristband, etc. The use of bed number or other location-related identifiers is not acceptable. The identification process should commence on entry of the patient into the hospital system.

Criteria

5.2.1.1 Policies and/or procedures that address the accuracy of patient identification are implemented.

5.2.1.2 The policies and/or procedures require the use of two patient identifiers unique to the patient, not including the use of the patient's room number or locations.

5.2.1.3 Patients are identified before administering medications, blood or blood products.

5.2.1.4 Patients are identified before taking blood and other specimens for clinical testing.

5.2.1.5 Patients are identified before providing treatments and procedures.

5.2.2 *The hospital develops an approach to improve the safety of verbal orders among caregivers.*

Standard Intent
Effective communication which is timely, accurate, complete, unambiguous and understood by the recipient reduces errors and results in improved patient safety. Communications can be electronic, verbal or written. The most error-prone communications are patient care orders given verbally and those given over the telephone, when permitted under local laws or regulations. Another error-prone communication is the reporting of critical test results, e.g. the clinical laboratory telephoning the patient care unit to report the results of an urgent test.

The hospital must develop a policy and procedure for verbal and telephone orders that includes: the writing down (or entering into a computer) of the complete order or test result by the receiver of the information; the receiver reading back the order or test result to the individual providing the order or test result; and the confirmation by the individual providing the order or test result that what has been written down and read back is accurate. The policy and procedure should identify permissible alternatives when the read-back process may not be possible, e.g. in the operating theatre and in emergency situations in the emergency department or intensive care unit. The development of this policy should involve all stakeholders to ensure that all aspects of the process are considered.

Criteria

5.2.2.1 Policies and procedures that address the accuracy of verbal and telephone orders are implemented.

5.2.2.2 The complete verbal or telephone order or test result is written down by the receiver of the order or test result, who signs as having done so.

5.2.2.3 The complete verbal and telephone order or test result is read back by a second person, who signs as having done so.

5.2.2.4 The order is confirmed by the individual who gave it by signing the relevant document as per hospital policy.

5.2.3 *The hospital develops an approach to improve the safety of high-alert medications.*

Standard Intent
High-alert medications, e.g. concentrated electrolytes, chemotherapy, blood thinning agents, drugs for intra-thecal administration, etc., are drugs that bear a heightened risk of causing significant patient harm when they are used in error. An important aspect of clinical risk management is therefore the identification of all such medications used in the hospital and the implementation of processes to reduce the risk of errors occurring. Medications which have similar packaging or a similar name (look alike, sound-alike medications) can easily lead to error, e.g. the accidental substitution of potassium chloride for sodium chloride when both are packaged in clear glass vials of the same size with the same colour writing on the vials and stored in close proximity.

High-alert medications can cause significant harm when used in error and should therefore be stored, labelled and retrieved for administration in a standardised manner throughout the hospital. The most effective way to reduce this risk is for these drugs to be stored in pharmacy and delivered to the unit only on request in response to patient needs. Where this is not practical, they should be:

- Stored in a manner that restricts access
- Stored only in-patient care areas where they will be used (e.g. intensive care unit, emergency department or operating department)
- Marked as high-risk substances in a standardised manner known to personnel

Policies and procedures regarding the management of high-alert medication should be developed collaboratively with all stakeholders. All relevant personnel members should be trained in the implementation of these policies and procedures and implementation should be monitored as part of the routine quality monitoring processes of each unit where high-alert medications are used.

Criteria

5.2.3.1 Policies and/or procedures that address the identification, location, labelling and storage of high-alert medications are implemented.

5.2.3.2 High-alert medications are available only in designated departments.

5.2.3.3 Measures to prevent the inadvertent administration of high-alert medications are implemented, e.g. hazard labels.

5.2.3.4 Clinical practice guidelines are available to guide prescribing of high-alert medications.

5.2.3.5 Patients prescribed high-alert medications are monitored for side effects or adverse drug reactions.

5.2.3.6 Policies and procedures that address the management of look-alike, sound-alike medications are implemented.

5.2.4 *The hospital develops an approach to ensuring correct site, correct procedure and correct patient surgery.*

Standard Intent

Wrong site, wrong procedure, wrong patient surgery is a disturbingly common occurrence in hospitals. These errors are the result of ineffective or inadequate communication between members of the surgical team, lack of patient involvement in site marking and lack of procedures for verifying the operative sites. Frequent contributory factors are: inadequate patient assessment, inadequate medical record review, organisational culture that does not support open communication among surgical team members, problems related to illegible handwriting and the use of abbreviations.

Hospitals must develop a policy and procedure that is effective in eliminating this disturbing problem. This is done most effectively by involving all role players in the development of these policies and procedures.

Marking of the operative site should be done in collaboration with the patient using an unambiguous mark appropriate for the type of surgery. The mark should be made by the person performing the procedure, should take place with the patient awake and aware if possible (exceptions would include patients with diminished consciousness due to their condition, e.g. head injury) and must be visible after the patient is prepared and draped. The mark must be made with ink that will not be washed away when the patient's skin is prepared for surgery. The operative site must be marked in all cases involving laterality, multiple structures (fingers, toes, lesions) or multiple levels (spine).

Criteria

5.2.4.1 Policies and procedures that establish uniform processes to ensure the identification of the correct site, correct procedure and correct patient are implemented.

5.2.4.2 The hospital uses a clearly understood mark for surgical site identification and involves the patient in the marking process.

5.2.4.3 The mark is made using ink that will not be washed away when the patient's skin is prepared for surgery.

5.2.4.4 The hospital uses a process to verify that all documents and items required to perform the marking are available, correct and functional.

5.2.5 *The hospital develops an approach to reduce the risk of patient harm resulting from falls.*

Standard Intent

Falls account for a significant proportion of patient injuries sustained during hospitalisation. In the context of the population served, the services provided and available facilities, the hospital should evaluate each patient's risk of falling and take action to reduce both the risk of falling and the risk of injury in the event of a fall. The evaluation could include assessing environmental factors (wet floors, unprotected ramps, etc.) and patient factors (fall history, medication and alcohol consumption review, gait and balance screening, use of walking aids, etc.). The hospital must establish a falls risk reduction programme based on appropriate policies and/or procedures which are implemented.

Criteria

5.2.5.1 Policies and procedures to reduce the risk of patient harm resulting from falls in the hospital are implemented.

5.2.5.2 Patients identified as being at high risk of falls due to their condition, diagnosis or location undergo a falls risk assessment as part of their initial assessment and following a change in condition, medication, etc. according to hospital policy.

5.2.5.3 Measures are implemented to reduce fall risk for those assessed to be at risk.

5.2.5.4 All falls are reported, recorded and monitored as part of the quality management system in each patient care unit.

5.2.6 *The hospital uses a defined process for identifying and managing sentinel events.*

Standard Intent

A sentinel event is an unexpected occurrence (as it is not related to the natural course of the patient's illness or underlying condition) involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence carries a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response." Joint Commission International

Every hospital should establish an operational definition of a sentinel event that includes at least:

a) Unanticipated death unrelated to the natural course of the patient's illness or underlying condition
b) Major permanent loss of function unrelated to the natural course of the patient's illness or
c) underlying condition
d) Wrong-site, wrong-procedure, wrong-patient surgery

The team responsible for risk management may wish to include other events as required by Namibian law or regulation or considered to be appropriate inclusions in relation to services offered by the hospital.

All events that meet the definition must be assessed by performing a credible root cause analysis. When the root cause analysis reveals that systems improvement or other actions can prevent or reduce the risk of such sentinel events recurring, appropriate action must be taken to achieve this risk reduction.

It is important to note that the term "sentinel event" does not always refer to an error or mistake or suggest any particular legal liability. Certain adverse events related to specific processes should always

result in intense analysis in order to understand the cause and prevent recurrence. When appropriate to the hospital's services, these events include:

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

Criteria

5.2.6.1 The team responsible for risk management has established a definition of a sentinel event that includes (a)-(c) in the standard intent above as a minimum.

5.2.6.2 Relevant personnel are trained in the procedures relating to the reporting and investigation of sentinel events.

5.2.6.3 The hospital conducts a root cause analysis on all sentinel events within a time period specified by the hospital's leaders.

5.2.6.4 The hospital's leaders take action on the results of the root cause analysis.

5.2.6.5 Intense analysis of data takes place when adverse levels, patterns or trends occur.

5.3 Occupational Health and Safety

5.3.1 *As part of risk management, an occupational health and safety system is implemented in accordance with current legislation.*

Standard Intent

Hospitals must ensure the safety of personnel, patients and visitors in accordance with Namibian occupational health and safety legislation. Whatever the legislative requirements, the hospital's occupational health programme should address the following issues as a minimum:

a) Protective clothing and equipment for personnel
b) Vaccination of personnel against high risk infections, e.g. Rubella and
c) Hepatitis B
d) Needlestick injuries
e) Manual handling injuries (ward personnel and support personnel, e.g. stores)
f) Medical surveillance arrangements for employees in high risk services, e.g. TB services

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

To plan effectively, the hospital must be aware of all risks present in the hospital. Once these risks are identified, the leaders responsible for managing them must develop a proactive plan to reduce those risks, e.g. TB screening, training in manual handling, monitoring of sharps disposal, etc. Where required by Namibian law, incidents and occupational diseases such as TB, HIV, Hepatitis B and C, injury on duty, etc. must be reported in accordance with these requirements.

It is expected that every hospital will provide an occupational health service for its employees. However, some components of the service may be delivered by another service provider. In the latter case, only relevant criteria will be assessed.

Criteria

5.3.1.1 Where applicable a health and safety committee is constituted in terms of current legislation.

5.3.1.2 Policies and procedures on all aspects of health and safety that guide personnel in maintaining a safe work environment are implemented.

5.3.1.3 Management makes provision for occupational health services according to a documented policy framework, which includes (a)-(e) in the standard intent above as a minimum.

5.3.1.4 The person(s) providing the Occupational Health Service has access to a qualified Occupational Health practitioner.

5.3.1.5 The hospital provides information and training on risks specific to the healthcare workers.

5.4 Safety and security

5.4.1 *A security system is maintained for the routine monitoring and safeguarding of the premises, patients, personnel, volunteers and visitors.*

Standard Intent
The senior management team has a responsibility to ensure that the hospital, personnel, volunteers, patients and visitors are safe from attacks or theft. The team responsible for risk management should ensure that systems are developed and implemented to provide protection from such incidents, including the identification of specific areas of the hospital and patient groups that are particularly vulnerable, e.g. remote areas of the grounds with poor lighting and newborns in the maternity unit. Additional security measures should be provided for these areas and groups.

Security services can be provided by personnel employed directly by the hospital or by contracted services and must include both the external and internal security monitoring of the hospital facilities. The powers and duties of the security personnel must be documented, either as part of the health and safety systems or in the agreement with a contracted service provider. This is particularly important in emergency planning, where the role of the security service must be clearly defined, e.g. in crowd control.

These activities of security personnel should be monitored as part of ongoing quality management.

Criteria

5.4.1.1 Internal security is provided 24 hours per day, seven days per week.

5.4.1.2 External security is provided 24 hours per day, seven days per week.

5.4.1.3 Policies on the management of weapons are implemented.

5.4.1.4 Policies on the management of violence and aggression are implemented.

5.4.1.5 Where vulnerable patients are cared for, special safety and security measures are implemented.

5.4.1.6 There is a mechanism known to personnel for summoning the assistance of the local security/police/protection service in case of an emergency.

5.4.2 *Structured systems to ensure fire safety are implemented.*

Standard Intent

Fire is an ever-present risk in a hospital. The team responsible for risk management needs to plan for:

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

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

The fire safety plan must identify the:

- Frequency of inspection, testing and maintenance of fire protection and safety systems, consistent with legislative and regulatory requirements
- Process for testing the plan for safe evacuation of the hospital in the event of a fire or smoke, at least annually
- Education of personnel to ensure effective protection and evacuation of patients in the event of an emergency

All inspections, testing and maintenance must be documented.

The team responsible for risk management should develop and implement a policy and plan to eliminate smoking in the hospital's facilities or to limit smoking to designated non-patient care areas. As the application of fire safety regulations may differ between authorities within Namibia, it is essential that some form of fire safety certification is made by relevant authorities, either in a letter or a formal certificate. This certification document should state the norms/standards/regulations against which the certification of compliance was issued. In most instances this certification remains valid until building alterations or additions take place. However, where this is not the case the hospital must ensure that the certificate remains current.

Criteria

5.4.2.1 Structured systems and processes to ensure that all occupants of the hospital facilities are safe from fire or smoke are implemented.

5.4.2.2 Documented evidence is available from the relevant authority to confirm that the hospital complies with applicable laws and regulations in relation to fire safety.

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

5.4.2.4 Flammable materials are clearly labelled and safely stored.

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

5.4.2.6 A floor plan is displayed, which shows the location of fire fighting equipment, evacuation routes and emergency exits.

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

5.4.2.8 The hospital has implemented a policy regarding smoking, which applies to patients, families, visitors, personnel and volunteers.

5.4.3 *A documented plan to respond to emergencies is developed and rehearsed.*

Standard Intent
Community emergencies, epidemics and disasters, e.g. damage to patient care areas as a result of an earthquake, or infections that affect large numbers of personnel, may directly involve the hospital. The hospital should also be prepared for bomb threats, fire, flooding, natural disasters, failure of water and electrical supplies, hostage taking, explosions and the consequent loss of vital services. There may be a time when it is necessary to evacuate patients. This can only be done quickly and effectively if personnel are trained in evacuation procedures. To respond effectively, the team responsible for risk management must develop a plan and test it. The plan must include processes to access alternative care sites when necessary and alternative sources of medical supplies, communications equipment, food and water.

Criteria

5.4.3.1 There is a documented plan to deal with internal and external emergencies.

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

5.5 Waste management

5.5.1 *The hospital has documented control systems for the handling, storage and disposal of healthcare waste.*

Standard Intent
Household waste, hazardous wastes, (e.g. chemicals, hazardous gases and vapours), pharmaceutical, laboratory and infectious waste, must be identified and safely controlled according to documented systems.

According to the World Health Organisation (WHO) "healthcare waste (HCW) is a by-product of healthcare that includes sharps, non-sharps, blood, body parts, chemicals, pharmaceuticals, medical devices and radioactive materials. Poor management of HCW exposes healthcare workers, waste handlers and the community to infections, toxic effects and injuries." All healthcare waste is regarded as hazardous or potentially hazardous. The waste management system should be included in the hospital's risk management systems.

Criteria

5.5.1.1 Waste is managed according to documented systems consistent with legislation, local by-laws and regulations.

5.5.1.2 Control systems include safe handling of different types of waste.

5.5.1.3 Control systems include safe storage of different types of waste.

5.5.1.4 Control systems include safe disposal of different types of waste.

5.5.1.5 Control systems include the procedures to be adopted if spills occur.

5.5.1.6 Control systems include the use of personal protective equipment when handling waste.

5.5.1.7 There is a colour-coding system for bags to be used for the segregation of different types of waste.

6 Resuscitation System

OVERVIEW OF RESUSCITATION SYSTEM

In any healthcare setting it is essential that all personnel are able to resuscitate patients in a medical emergency. Resuscitation calls for an integrated, multidisciplinary approach and the coordination of skills of these disciplines.

The first step in developing a resuscitation programme is the development of protocols relating to:

- The levels of resuscitation to be provided (BLS, ALS, ATLS, ACLS, PALS, etc.)
- Who should provide resuscitation and at what level (e.g. all personnel trained in either CPR, Family and Friends or BLS; each emergency department shift to include at least one professional member of personnel trained in ATLS, etc.) according to the level of service provided
- The skills, training and competence required
- Availability of equipment

To facilitate the provision of effective resuscitation, relevant equipment must be readily available, routinely checked according to hospital policy and functional. The medical equipment manager is, therefore, an essential member of the resuscitation committee.

The concept of the 'medical emergency team' (MET) rather than a cardiac arrest team must be emphasised. It is accepted that patient outcomes are better when cardiac arrest is prevented – therefore the focus ought to be on early identification of clinical signs of deterioration which predict the onset of cardiac arrest and early, aggressive expert care. Patient safety and preventable in-hospital mortality remain crucial aspects of optimum medical care and continue to receive public scrutiny.

Signs of physiological instability often precede overt clinical deterioration in many patients. Studies of in-hospital performance highlight a 'failure to rescue' in acutely ill patients – a deficiency strongly associated with serious adverse events, cardiac arrest or death. Rapid response systems (RRSs) and the MET should provide early specialist critical care to those patients with unequivocal physiological instability or patients whose clinical status evokes significant concern in hospital personnel in a noncritical care environment. This intervention aims to prevent serious adverse events, cardiac arrests and unexpected deaths.

Prevention of cardiopulmonary arrest remains the best strategy to decrease in-hospital patient mortality.

Standards

6.1 Resuscitation committee

6.1.1 *A resuscitation committee coordinates the management of resuscitation equipment, procedures and training systems.*

Standard Intent

Resuscitation equipment and procedures should be standardised throughout the hospital.

Standardised resuscitation processes require:

- Coordination among those who provide and maintain the equipment
- Availability of required equipment
- Availability of required drugs
- Initial and ongoing training of personnel in the use of equipment and execution of procedures
- Maintenance and monitoring of equipment
- Current, evidence-based guidelines for resuscitation

A competent individual who has the necessary knowledge and expertise with regard to resuscitation and the equipment required should provide this coordination. The resuscitation coordinator should be a registered healthcare professional with at least Basic Life Support training (BLS) or equivalent and have the necessary authority to be able to oversee and ensure the safe and efficient functioning of the resuscitation service throughout the institution

Deficiencies in the system regarding equipment, its use and the knowledge and skills required by those who carry out resuscitation should be identified, documented and acted upon. Each hospital should identify those members of personnel to be trained in emergency life support and the level of training (basic or advanced) appropriate to their role in the hospital. The person(s) providing the training must be currently registered and/or accredited with a recognised body as a resuscitation trainer. Training in many instances can be outsourced.

Criteria

6.1.1.1 The hospital identifies a resuscitation committee to advise on the resuscitation equipment required and the procedures to be followed.

6.1.1.2 Each committee member's responsibility for resuscitation is documented in a job description.

6.1.1.3 A suitably qualified and experienced health professional is appointed as the resuscitation coordinator.

6.1.1.4 The medical equipment coordinator is on the committee.

6.1.1.5 A designated individual provides information, instruction and training on resuscitation to the personnel of the hospital.

6.1.1.6 The committee checks and documents that systems for the provision of emergency power are regularly checked according to hospital policy.

6.1.1.7 The committee checks and documents that systems for the supply of gases and vacuum are regularly checked according to hospital policy.

6.1.1.8 A member of the resuscitation committee visits all clinical departments where resuscitation equipment is kept at least monthly to monitor that requirements relating to resuscitation medication, supplies and equipment are met.

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

6.1.1.10 Policies and procedures relating to the acquisition, maintenance and checking of resuscitation equipment are implemented.

6.1.1.11 Current, evidence-based clinical practice guidelines for resuscitation are prominently displayed in all areas where resuscitation is likely to take place and easily accessible in all other areas.

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

6.2 Equipment and medications

6.2.1 *Essential resuscitation equipment and medications are available in each patient care area.*

Standard Intent

The resuscitation committee must ensure that the correct equipment is available for resuscitation. This requires agreeing to and listing those items of equipment deemed necessary for resuscitation. The resuscitation committee or equivalent must ensure that each patient care area has access to a defibrillator or automated external defibrillator (AED) within three minutes of any patient who suffers a cardiac arrest. A resuscitation trolley must be available within one minute of any patient who collapses. Resuscitation equipment must include the following as a minimum:

a) Defibrillator with adult paddles/pads (and infant paddles/pads where applicable)
b) ECG monitor
c) CPR board (if required, e.g. not required for certain types of beds such as ICU or certain trauma beds)
d) Suction apparatus (electrical and/or alternative) plus range of soft and hard suction catheters
e) Bag-mask manual ventilator
f) Range of endotracheal tubes (ETTs) and two laryngoscopes with a range of straight and curved blades, spare batteries and spare globes where applicable
g) Introducer/stylet for endotracheal intubation
h) Syringe to inflate ETT cuff
i) Oropharyngeal tubes
j) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
k) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
l) Medication for cardiac arrest, coma, seizures, anaphylactic shock, etc. (including paediatric doses)

Members of the committee must ensure that regular equipment checks are carried out. Individuals in patient care areas are responsible for the checking of resuscitation equipment daily or after each use, whichever comes first. Records of these tests must be maintained. Documented policies and procedures detailing what these checks will encompass and who will be responsible for their implementation must be in place. Documented policies and procedures as well as evidence in the form of a visitation logbook or similar record system are required.

Comprehensive checklists must be available and should indicate both the recommended minimum quantities of items on the trolley and the quantities actually present. These checks must also include expiry dates with regard to all limited lifespan items such as medication, ECG electrodes, tubes, catheters, etc.

Criteria

6.2.1.1 The hospital has an updated list of equipment required for resuscitation in each area, including items as listed in the intent statement.

6.2.1.2 The committee ensures that resuscitation equipment is readily accessible to every patient care area in the hospital.

6.2.1.3 The committee checks and documents that resuscitation equipment and drugs are checked daily, or immediately after use (whichever is the sooner), by persons identified to be responsible for this.

6.3 Education and training

6.3.1 *All personnel are suitably trained and educated to provide resuscitation and competencies are regularly tested.*

Standard Intent

It is the responsibility of management to ensure that training and education needs for resuscitation are identified, that appropriate training and education are provided and that personnel demonstrate proof of competence.

The standards do not specify levels of training, as this will be decided by the hospital's senior management team and included in the policy framework and/or continuing education strategy. Every person employed in a hospital should be trained in basic CPR. Evidence of training of different levels of personnel is required to assess compliance. It is recommended that at least 80% of the clinical personnel complement on duty in patient care areas have been trained according to hospital policy.

Criteria

6.3.1.1 The resuscitation committee develops a continuing education strategy to ensure that all personnel in the hospital are trained in cardio-pulmonary resuscitation.

6.3.1.2 There is evidence that all members of the resuscitation committee, as well as relevant personnel, attend courses and seminars on resuscitation and that records of attendance are kept.

6.3.1.3 New healthcare professionals employed in patient care areas are provided with resuscitation training within one month of appointment.

6.3.1.4 The continuing education strategy ensures that resuscitation training of personnel is kept current.

6.3.1.5 Dated records are kept of attendance at in-service training programmes.

6.3.1.6 There is a mechanism whereby personnel show proficiency in resuscitation techniques.

6.4 Quality improvement

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

Standard Intent

This refers to the implementation of hospital quality improvement processes (Service Element 7). It is the responsibility of management to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

- Clinical audits on resuscitations performed and documented evidence of remedial actions undertaken
- Progress made in the number of personnel trained according to the education strategy
- Monitoring adherence to policies and procedures with regard to daily checking of the emergency trolleys
- Monitoring the frequency and causes of adverse events related to the operations of the resuscitation service

- Monitoring the frequency of resuscitations and why these patients were not identified pre-arrest

The minimum requirement would be the evaluation of resuscitation events.

The following will be evaluated:

- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC

Criteria

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

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

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

6.4.1.4 A documentation audit system is in place.

7 Information Management and Quality Improvement

OVERVIEW OF INFORMATION MANAGEMENT AND QUALITY IMPROVEMENT

This Service Element describes a comprehensive approach to quality improvement, which includes the following:

- Planning for improvement in quality, including information requirements
- Monitoring how well interventions are working by means of:
    - Repeated indicator data collection
    - Data analysis
    - Implementing and sustaining changes that result in improvement

When performed well, these activities provide the framework for the hospital and its leaders to create a culture of continuous quality improvement, providing quality patient care in a safe, well-managed environment.

The purpose of this Service Element is to guide clinical and non-clinical personnel, both managers and those responsible for service delivery, in the development and implementation of an integrated, coordinated, hospital-wide quality improvement system. The principles outlined here can be applied to daily tasks and functions and used to increase efficiency and effectiveness of service delivery.

The quality management programme must have clear leadership to achieve maximum benefit. Quality improvement activities should be guided by an overall framework implemented throughout the hospital. The hospital-wide programme should include the full spectrum of clinical and managerial activities, focusing on the reduction of risk associated with variation in these activities. Continuous improvement and the maintenance of improvements already achieved require continuous monitoring, analysis and interpretation of key indicator data, followed by appropriate interventions when problems are identified. The programme should take into account that most clinical care involves more than one profession. In order for quality improvement activities to be effective, quality improvement interventions should be developed and implemented collaboratively and coordinated between all stakeholders involved in the process.

The framework presented in these standards is suitable for a wide variety of structured processes for quality improvement. Over time, hospitals that follow this framework will:

- Develop greater leadership support for a hospital-wide quality improvement programme
- Train and involve more personnel in monitoring and improvement activities
- Set clearer priorities for what to monitor and what to improve
- Base decisions on indicator data
- Make improvements based on comparison with other hospitals, both nationally and internationally.

Effective quality management and improvement cannot be achieved without adequate data collection, aggregation, analysis and reporting to support the process. Just like human, material and financial resources, information is a resource that must be managed effectively by the hospital's leaders. Every hospital should seek to obtain, manage and use information to improve patient outcomes as well as individual and overall hospital performance. Aggregated data from risk management, utility system management, infection control and utilisation review can help the hospital understand its current performance and identify opportunities for improvement. Over time, hospitals should become more effective in:

- Identifying information needs
- Designing an information management system
- Defining and capturing data and information
- Analysing data and transforming it into useful information
- Transmitting and reporting data and information
- Integrating and using information

Although computerisation and other technologies improve efficiency, the principles of good information management apply to all methods, whether paper-based or electronic.

Standards

7.1 Planning and implementation of information management systems

7.1.1 *The hospital plans and implements processes to meet the information needs of clinical and managerial services, and those outside the hospital that require data and information from the hospital.*

Standard Intent
Information generated during patient care should be used for the safe and effective management of a hospital. The ability to collect and provide information requires effective planning. Planning should incorporate contributions from a variety of sources, including:

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

The most urgent information needs of these sources will influence the hospital's information management strategies and its ability to implement those strategies. The strategies must be appropriate for the hospital's size, complexity of services, availability of trained personnel and other human and technical resources. The plan must be comprehensive and include all departments and services in the hospital.

Criteria

7.1.1.1 Information systems are developed and implemented in the hospital.

7.1.1.2 The senior management team, in collaboration with all departments, identify key indicators and other information required to monitor quality assurance and improvement processes.

7.1.1.3 Clinical and managerial personnel participate in information technology decisions.

7.1.2 *Confidentiality, security and integrity of data and information are maintained.*

Standard Intent
This standard applies to patient information as well as documentation relating to the management of the hospital, legal documentation, research and education. The principles outlined here apply equally to paper-based and electronic documentation. The person responsible for information management systems must have the required training and experience to perform their functions. The hospital should determine and define the level of security and confidentiality to be maintained for different categories of information.

Access to each category of information must be based on need and defined by job title and function. An effective process defines:

- Who has access to information
- The information to which an individual has access
- The user's obligation to keep information confidential
- The process to be followed when confidentiality and security are violated

One aspect of maintaining security of patient information is to determine who is authorised to obtain a patient record and to make entries into the patient record. The hospital must develop a policy to

authorise such individuals and identify the content and format for entries into patient records. There must be a process to ensure that only authorised individuals make entries into patient records.

The hospital must maintain the security and confidentiality of data and information and be especially careful about preserving the confidentiality of sensitive data and information. The balance between data sharing and data confidentiality must be addressed. The hospital must develop and implement a policy to guide the retention and destruction of hospital, legal and research information. These policies must ensure that confidentiality of the information is maintained at all times. For electronic systems, adequate and appropriate back-up systems must be in place.

Criteria

7.1.2.1 A designated individual with appropriate training and experience is responsible for information management systems.

7.1.2.2 Confidentiality of data and information is maintained.

7.1.2.3 Security and integrity of data and information is maintained.

7.1.3 *Information management systems are implemented and supported by sufficient personnel and other resources.*

Standard Intent

The hospital's information management systems, once completed and approved, should be implemented. The hospital must provide the personnel, technology and other resources necessary to implement the information management systems and meet the identified information needs of the healthcare providers, managers and others. Individuals in the hospital who generate, collect, analyse and use data and information should be educated and trained to participate effectively in the management of information. Such education and training enables these individuals to:

- Understand the security and confidentiality of data and information
- Use measurement instruments, statistical tools and data analysis methods
- Assist in interpreting data
- Use data and information to assist in decision making
- Educate and support the participation of patients and families in care processes
- Use indicators to assess and improve care and work processes

Individuals should be appropriately educated and trained in regard to their responsibilities, job descriptions and data and information needs. Information management technology represents a major investment of resources for a hospital. For this reason, technology must be carefully matched to the current and future needs of the hospital and the available resources. New technology must be integrated with existing information management systems and accommodate the information management activities of all departments and services of the hospital. This requires that key clinical and managerial personnel participate in the selection process for new technology. The management of the hospital should ensure that personnel have the required supplies, registers, check lists, forms, etc.
for information management.

Criteria

7.1.3.1 Sufficient personnel support implementation of the information management system.

7.1.3.2 Decision-makers and others are provided with appropriate training in the principles of information management.

7.1.3.3 Required technology and other resources support the implementation.

7.2 Data processing and analysis

7.2.1 *The hospital has a process to aggregate data for user needs.*

Standard Intent
The hospital collects, and analyses aggregated data to support patient care, quality improvement and management of the hospital.

Criteria

7.2.1.1 The hospital has a process to aggregate data.

7.2.1.2 Clinical and managerial data and information are integrated as needed to support decision making.

7.2.1.3 Aggregated data and information are used to support patient care.

7.2.1.4 Aggregated data and information are used to support management of the hospital.

7.2.1.5 Aggregated data and information are used to support the quality management programmes.

7.2.1.6 Appropriate data is collected and used to study areas targeted for improvement.

7.2.1.7 Appropriate data is collected and used to monitor and evaluate the effectiveness of interventions implemented to achieve improvements.

7.2.1.8 The results of these monitoring activities are communicated to the leaders and governance structure of the hospital and to other relevant stakeholders, such as departmental personnel responsible for the process under consideration.

7.2.2 *The hospital contributes to external databases.*

Standard Intent
By participating in external performance databases, a hospital can compare its performance with that of other similar hospitals locally, nationally or internationally. Performance comparison is an effective tool for identifying opportunities for improvement and documenting the hospital's performance level. Healthcare networks and those purchasing or paying for health care often request such information.

Criteria

7.2.2.1 The hospital has a process to participate in and/or use information from external databases.

7.2.2.2 Data or information is contributed to external databases as required by law or regulation, where applicable.

7.2.2.3 Notifiable diseases are reported within an acceptable time frame, according to hospital policy.

7.2.2.4 The hospital compares its performance with that of other, similar hospitals, using external reference databases.

7.3 Quality leadership and design

7.3.1 *There are documented quality management and improvement processes which are implemented throughout the hospital.*

Standard Intent
Effective leadership and planning are essential in the initiation and maintenance of improvement. The governing leaders of the hospital are as important in the process as the managers and clinical care providers in the hospital. Each leader should participate in establishing the hospital's commitment to improvement, the approach to be used and the implementation of monitoring and evaluation activities. The leaders should shape the quality culture of the hospital through their vision and support.

A framework for the quality improvement system should be provided by documenting the processes to be followed and ensuring that these processes are implemented in all services in the hospital in a planned and coordinated manner.

Well-designed quality improvement processes draw on a variety of information sources and should meet the following criteria:

- Be consistent with the hospital's mission and plans
- Meet the needs of patients, families, personnel and others
- Use current practice guidelines, clinical standards, scientific literature and other relevant evidence-based information on clinical practice design
- Be consistent with sound business practices
- Consider relevant risk management information
- Use information from related improvement activities
- Integrate and connect systems of service delivery

A primary responsibility of leaders is to set priorities. Hospitals typically find more opportunities for quality monitoring and improvement than they have human and other resources to accomplish. The leaders should therefore prioritise those critical, high risk or problem-prone areas that relate most directly to the quality of care and safety of the environment. The leaders must use available data and information to identify areas to be prioritised.

Criteria

7.3.1.1 There is a system for the implementation of quality management and improvement processes.

7.3.1.2 Managerial and clinical leaders and relevant stakeholders participate in the implementation of the quality management and improvement processes.

7.3.1.3 The processes reflect the scope of service delivery in relation to managerial, clinical and support services (including formal educational services where applicable).

7.3.1.4 The leaders identify priorities for monitoring activities.

7.3.1.5 The documented quality improvement processes include all components of quality management activities, i.e., standard and indicator selection, monitoring, evaluation and remedial action.

7.3.2 *The leaders coordinate the quality management and improvement processes and provide technological and other support.*

Standard Intent
Central coordination of quality management and improvement activities ensures the efficient use of resources. This can be achieved through a quality steering group or a committee that provides effective supervision of quality management and improvement activities throughout the hospital. One of the responsibilities of such a group is to communicate information about the quality management and improvement processes to personnel on a regular basis.
The monitoring of clinical and managerial functions in a hospital results in the accumulation of data and information. An understanding of how well the hospital is doing rests on the analysis of the data and information over time and comparison with other hospitals. For large or complex hospitals this tracking and comparison may require technology and/or personnel members with data management experience. The leaders of a hospital must understand the monitoring and improvement priorities and provide support consistent with the quality management priorities and resources of the hospital. The planning of data collection, analysis and interpretation and the application of the information generated by this process require knowledge and skills that most personnel do not have or do not use regularly. When asked to participate in the process, therefore, these individuals should receive training consistent with their role in the process. The hospital should identify or provide a knowledgeable trainer for this education.

Personnel selected to participate in management and improvement processes should be those closest to the activities being monitored, studied or improved. Both managerial and clinical personnel should participate in the process. Over time an increasing number of personnel should have the opportunity to be trained and participate.

Criteria

7.3.2.1 Quality management and improvement processes are coordinated among all relevant services.

7.3.2.2 The leaders provide the required technology and support.

7.3.2.3 There are relevant training processes to equip personnel with the necessary competencies for the design, implementation and evaluation of quality management and improvement processes.

7.4 Clinical and managerial quality monitoring

7.4.1 *Clinical processes are reviewed, and the data obtained is used to drive improvements in patient care.*

Standard Intent
The goals of hospitals include:

- Standardising clinical care
- Reducing risks within care, particularly those associated with critical decision steps
- Providing clinical care in a timely, effective manner
- Efficient use of available resources

Clinical audit provides an effective method of describing the current quality of service provided, implementing action plans to improve patient care, evaluating progress towards desired targets and monitoring maintenance of improvements over time. This can be achieved using various approaches. For example, care providers should seek to develop clinical care processes and make clinical decisions based on the best available current evidence-based guidelines. Clinical practice guidelines are useful

tools in the effort to understand and apply the best available scientific evidence to a particular diagnosis or condition.
In addition, care providers should seek to standardise care. Clinical care pathways are useful tools to ensure effective integration and coordination of care and efficient use of available resources.
Clinical practice guidelines relevant to the hospital's patient population and mission must be: - Selected from among guidelines applicable to the patient services provided (mandatory national guidelines are included in this process where available)

- Evaluated for their applicability and scientific rigour
- Focus on high volume, high risk, high cost and problem prone conditions, including conditions presenting infrequently, e.g., hepatitis E in a non-endemic area
- Adapted to the technology, drugs and other resources of the hospital or to accepted national professional norms where necessary, e.g., if guidelines from another country are used due to the non-availability of local guidelines
- Formally approved or adopted by the appropriate authority within the hospital, e.g., the head of department or hospital management
- Implemented and monitored for consistent use and effectiveness
- Supported by personnel trained to apply the guidelines or pathways
- Periodically updated according to hospital policy

Clinical audits should be performed to confirm adherence to the care processes advocated by these guidelines and to monitor patient outcomes. "Clinical audit involves systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient". (U.K. Department of Health, 1993)
The process of clinical audit related to implementation of guidelines should include the following steps:

1) Identify a problem or issue, e.g., high levels of non-compliance with treatment or high maternal mortality rates relative to similar facilities in the locality.
2) Set criteria and standards, e.g., 80% of patients should comply with treatment regimens or maternal mortality rate should be 1:1 000.
3) Determine current situation, i.e., initial data collection, e.g., what are the current rates of treatment compliance or maternal mortality.
4) Compare current situation (3) with desired performance (2).
5) Analyse current situation and practices to determine reasons for the discrepancies observed, e.g. Are patients able to attend the hospital to collect medication, is medication available, is emergency blood available for postpartum haemorrhage cases, is access to theatre delayed for mothers who require emergency caesarean section, etc.
6) Develop plans to address the causes for the deficiencies, e.g., arrange medication to be taken to localities closer to the patients to make it easier for them to collect the medication, ensure immediate theatre access, etc. (It is important to involve all stakeholders in the creation of these plans.)
7) Implement the plans for a predetermined period of time, e.g., six months. (It is important that this time period is long enough to allow for the full effect of the intervention to develop.)
8) Repeat data collection.
9) Analyse the data.
10) Compare current data to baseline (initial) data and determine any change in performance.
11) If progress is not according to plan, repeat steps 5-10.
12) If the targets set have been achieved, monitor performance to ensure improvements are maintained.
13) If appropriate, set new targets for further improvements in performance.
14) Provide feedback to all stakeholders regularly to keep them updated on progress and motivated to remain engaged in the process.
15) Share lessons learned as widely as possible to accelerate the potential gains in service delivery that can be achieved by means of clinical audit.

Criteria

7.4.1.1 The leaders identify key measures to monitor the quality of clinical processes.

7.4.1.2 Leaders use clinical practice guidelines to guide patient care processes.

7.4.1.3 Clinical audits are performed to evaluate the quality of care provided, drive improvements in service provision and monitor performance over time.

7.4.1.4 Clinical processes are evaluated, and the results used to drive improvements in patient care.

7.4.1.5 Medical, nursing and other clinical leaders use available and relevant clinical practice guidelines in clinical monitoring as part of a structured clinical audit.

7.4.1.6 Professional performance is monitored as part of clinical monitoring.

7.4.2 *The quality of clinical record keeping is monitored by means of patient record audit.*

Standard Intent

Every hospital must have a process to assess the quality and completeness of patient records. This process is an integral part of the hospital's performance improvement activities and should be carried out regularly at a frequency determined by hospital policy.

Clinical record review should be based on a representative sample (i.e. a sufficiently large sample which includes records for all practitioners providing patient care and all types of care provided). The review should be conducted by medical, nursing and other clinical professionals authorised to make entries in the patient record. The focus of the review should be on the quality of the record and clinical information available during the care process. Patient records of adequate quality will provide sufficient information for a practitioner to be able to pick up the patient's care as if they had been the main professional responsible for the patient up until that point, i.e. the record should enable seamless and continuous care, in spite of that care being provided by a series of different healthcare professionals over time. It should also provide effective communication between all members of the multidisciplinary team.

The hospital's record review process should include the records of patients currently receiving care as well as the records of discharged patients.

Criteria

7.4.2.1 Patient clinical records are reviewed regularly.

7.4.2.2 The review is conducted by medical, nursing and other personnel, who are authorised to make entries in patient records or to manage patient information.

7.4.2.3 Records of active and discharged patients are included in the review process.

7.4.2.4 Deficiencies in the quality of record keeping are addressed by appropriate interventions.

7.4.2.5 The effectiveness of these interventions is evaluated as part of the ongoing monitoring of the quality of patient records.

7.4.2.6 Where the use of abbreviations is permitted, a standardised abbreviation list is available.

7.4.2.7 Standardised diagnosis and procedure codes are used as required by Namibian directives.

7.4.3 *There are relevant managerial quality monitoring systems.*

Standard Intent

Quality management and improvement should be data driven. Because most hospitals have limited resources, it is unlikely that they will be able to monitor everything they would like to. Therefore, each hospital must select which managerial and support services and outcomes are most important to the hospital's mission, patient needs, and services provided.

Monitoring often focuses on those services and outcomes that are high risk, high volume, or problem prone at hospital and departmental level. The leaders of the hospital should be responsible for the final selection of the key measures to be included in the hospital's monitoring activities. The measures selected should relate to those important areas identified, which could include financial issues, stock control, loss control, human resources, risk management, performance management, etc.

For each of these areas leaders decide:

- The process, procedure or outcome to be measured
- How measurement will be accomplished
- The frequency of measurement

Identification of the process, procedure or outcome to be measured is clearly the most important step. Where outcome measures are selected as part of the quality monitoring process, it is best to select outcomes that can be clearly defined and are under the control of the hospital.

Criteria

7.4.3.1 Appropriate data is collected and used to study areas targeted for improvement.

7.4.3.2 Appropriate data is collected and used to monitor and evaluate the effectiveness of interventions implemented to achieve improvements.

7.4.3.3 The results of these monitoring activities are communicated to the leaders and governance structure of the hospital.

7.4.4 *Analysed data is used to improve the quality of managerial and clinical services.*

Standard Intent

To reach conclusions and make decisions, data must be aggregated, analysed and transformed into useful information. Data analysis should involve individuals with an understanding of information management, skills in data aggregation and the use of various statistical tools and the individuals responsible for the process or outcome being measured. These individuals may represent clinical, managerial or any other departments and services in the hospital. Thus, data analysis provides continuous feedback of quality management information to help those individuals make decisions and continuously improve clinical and managerial processes.

The hospital should determine how often data is aggregated and analysed. The frequency depends on the activity or area being measured, the frequency of measurement and the hospital's priorities. For example, clinical data may be analysed weekly to meet local regulations and data related to patient falls may be analysed quarterly if falls are infrequent. Aggregation of data at pre-determined points in time enables the hospital to judge the stability of a particular process or the predictability of a particular outcome compared to the expected outcome.

When the data suggests an undesirable change from what is expected, intense analysis should be done to determine where best to focus improvement. In particular, intense analysis is initiated when levels, patterns or trends vary significantly or undesirably from:

- What is expected
- That of other hospitals with similar patient profiles, service provision and level of care
- Recognised standards

Each hospital must establish which events are significant and the process for their intense analysis.

When undesirable events can be prevented, the hospital must implement preventive strategies. The goal of data analysis is to be able to compare a hospital in four ways:

- With itself over time, e.g., month to month, or one year to the next
- With other similar hospitals, e.g., through reference databases
- With standards, e.g., standards set by accrediting and professional bodies or those set by Namibian law or regulation
- With desirable practices identified in the literature, e.g., practice guidelines

These comparisons help the hospital to understand the source and nature of undesirable change and help to focus improvement efforts. Understanding statistical techniques is helpful in data analysis, especially in interpreting variation and in deciding where improvement needs to occur. Run charts, control charts, histograms and Pareto charts are examples of statistical tools useful in understanding trends and variations in health care.

Criteria

7.4.4.1 Clinical monitoring data is used to monitor and evaluate the effectiveness of improvements.

7.4.4.2 Managerial monitoring data is used to monitor and evaluate the effectiveness of improvements.

7.4.4.3 Clinical and managerial data and information are integrated as needed to support decision making.

7.4.4.4 Comparisons are made over time within the hospital.

7.4.4.5 Comparisons are made with similar hospitals, when possible.

7.4.4.6 Comparisons are made with standards and desirable practices.

7.5 Achieving and sustaining quality

7.5.1 *Improvement in quality is achieved and sustained.*

Standard Intent

The hospital should use the information from data analysis to identify potential improvements and/or reduce or prevent adverse events. Routine monitoring data as well as data from intensive assessments contribute to an understanding of where improvement should be planned and what priority should be given to the improvement.

The hospital should use appropriate resources and involve those individuals, disciplines and departments closest to the activities to be improved. Responsibility for planning and carrying out improvement should be assigned to individuals or to a team. Any training required should be provided and information management or other resources made available.

Once change is implemented, data should be collected during a test period to demonstrate that the planned change was actually an improvement. To ensure that the improvement is sustained, monitoring

data should then be collected for ongoing analysis. Effective changes should be incorporated into standard operating procedures and any necessary personnel education carried out. The hospital should document those improvements achieved and sustained as part of its quality management and improvement processes.

Criteria

7.5.1.1 The hospital documents the improvements achieved and sustained over time.

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

8 Prevention and Control of Infection

OVERVIEW OF PREVENTION AND CONTROL OF INFECTION

The goal of a hospital's infection surveillance, prevention and control system is to identify and reduce the risk of acquiring and/or transmitting infections among patients, personnel, contract workers, volunteers, students and visitors.

The infection control system may differ from hospital to hospital depending on the hospital's geographic location, patient volume, patient population served, type of clinical activities and number of personnel.

Common characteristics of effective systems are identified leaders, appropriate policies and procedures, personnel education and coordination of the programme throughout the hospital.

Current scientific information is required to understand and implement effective surveillance and control activities. Practice guidelines provide information on preventive practices and infections associated with clinical services. Applicable Namibian laws and regulations define elements of the basic processes and reporting requirements. Data should be collected and collated to support the tracking of risks, rates and trends in healthcare-associated infections, data analysis, interpretation of the analysed data and presentation of findings. In addition, infection control data and information should be managed in conjunction with that of the hospital's quality management and improvement programme.

Standards

8.1 Infection control management

8.1.1 *Coordinated processes to reduce the risk of healthcare-associated infections in patients and healthcare workers are designed and implemented in line with the hospital's risk management programme.*

Standard Intent

The infection control system should be guided by documented processes that identify and address infections that are epidemiologically important to the hospital. There should be systems in place to monitor infections, investigate outbreaks of infections, assess risk and set risk reduction goals. Each hospital must establish those epidemiologically important infections, infection sites and associated devices that will provide the focus of efforts to prevent and reduce the occurrence of healthcare associated infections.

They should consider, as appropriate, infections that involve:

- The respiratory tract such as the procedures and equipment associated with intubation, mechanical ventilation support and tracheostomy
- The urinary tract such as the invasive procedures and equipment associated with indwelling urinary catheters, urinary drainage systems and their care
- Intravascular invasive devices such as the insertion and care of central venous catheters and peripheral venous lines
- Surgical sites such as appropriate care and type of dressing for specific operations and associated aseptic procedures
- Epidemiologically significant diseases and organisms e.g., multi-drug resistant organisms and highly virulent infections
- Emerging or re-emerging infections within the community
- At risk populations, e.g., immuno-compromised, long-term care, ICU, etc.

One or more individuals acting on a full-time or part-time basis should direct the programme. The required qualifications for these individuals will depend on the activities they will carry out. For some positions, these requirements may be met through education, training and experience. Their

responsibilities may include, for example, the setting of criteria for defining healthcare-associated infections and establishing data collection methods and reporting processes.

Coordination should include communication with all departments in the hospital, to ensure that the programme is continuous and proactive. Whatever the mechanism chosen by the hospital to coordinate the infection control processes, all personnel should be represented and engaged in the activities. The disciplines involved will be determined by the size of the hospital and the services offered, e.g. epidemiologist, data collection expert, central sterilisation manager, operating theatre supervisor, hotel services managers, etc. The individual, committee or other mechanism must also monitor those housekeeping and other support service practices which may lead to the spread of infection, e.g. cleaning, linen supply, laundry services and waste disposal.

Criteria

8.1.1.1 A programme to reduce the risk of healthcare-associated infections to patients and healthcare workers is developed in line with the hospital's risk management programme.

8.1.1.2 The programme is appropriate to the size and geographic location of the hospital, the services offered, and the patients served.

8.1.1.3 Coordination of infection control activities involves medical, nursing and other personnel as appropriate to the hospital.

8.1.1.4 All patient, personnel and visitor areas of the hospital are included in the infection control activities.

8.1.1.5 Responsibility for coordinating the activities is assigned to one individual or a committee.

8.1.1.6 The individuals are competent to manage the scope and complexity of the activities.

8.1.1.7 The infection control activities are based on current scientific knowledge, accepted practice guidelines and applicable laws and regulations.

8.1.1.8 Information management systems support the infection control activities.

8.2 Infection control processes

8.2.1 *The hospital identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.*

Standard Intent

Hospitals assess and care for patients using many simple and complex processes, each associated with a level of infection risk to patients and personnel. It is thus important for a hospital to review those processes and, as appropriate, implement policies, procedures, patient and personnel education and other activities required to reduce the risk of infection.

Policies and procedures which address the following aspects of infection prevention and control should be included as a minimum:

a) Equipment cleaning, disinfection and sterilisation
b) Laundry and linen management
c) Management of healthcare waste

d) Ensuring that food preparation, handling, storage and distribution are safe and comply with Namibian laws, regulations and current acceptable practices
e) Housekeeping services
f) Operation of the mortuary area/holding room for the deceased
g) Separating patients with communicable diseases from those patients and personnel who are susceptible to infection due to immuno-suppression or other reasons
h) Management of viral haemorrhagic fevers
i) Implementation of prevention measures for urinary and respiratory infections, intravenous infusion sites and surgical wounds in clinical areas
j) Preparation of pharmaceutical compounds in the pharmacy
k) Cleaning of ambulances
l) Physical plant facilities, e.g., heating, ventilation and air conditioning systems

Criteria

8.2.1.1 The strategies to reduce healthcare-associated infections include systematic and proactive surveillance activities to determine endemic rates of infection.

8.2.1.2 The hospital has identified those processes associated with the risk of infection and implemented strategies to reduce such risk.

8.2.1.3 Policies and procedures to guide personnel in the implementation of adequate infection prevention and control measures, which include (a)-(l) in the standard intent above as a minimum, are readily accessible and implemented.

8.2.1.4 Processes associated with risk are documented.

8.2.1.5 The strategies include systems to investigate outbreaks of infectious diseases.

8.2.1.6 Epidemiologically significant diseases and organisms are included as appropriate to the hospital and its community.

8.2.1.7 Emerging or re-emerging infections are included as appropriate to the hospital and its community.

8.2.2 *Protective clothing, disinfectants and barrier techniques are available and used correctly when required.*

Standard Intent

Hand washing, barrier techniques and disinfecting agents are fundamental to infection prevention and control. The hospital must identify those situations in which the use of protective clothing is required and provide training in their correct use. Soap and disinfectants must be located in those areas where hand washing, and disinfecting procedures are required. Personnel must be educated in effective hand washing and disinfecting procedures as recommended in evidence-based guidelines on hand washing.

Criteria

8.2.2.1 The hospital identifies those situations for which protective clothing is required.

8.2.2.2 The correct use of protective clothing is monitored.

8.2.2.3 The hospital identifies those areas where hand washing, and disinfecting procedures are required.

8.2.2.4 The hospital ensures that hand washing facilities are provided in all areas where hand washing, and disinfection procedures are required.

8.2.2.5 The implementation of correct hand washing, and disinfecting procedures is monitored.

8.3 Obtaining of laboratory cultures

8.3.1 *Laboratory cultures are obtained from designated environmental sites in the hospital which are associated with significant risk of infection.*

Standard Intent
Infection surveillance procedures rely on specimen collection from those areas of the hospital associated with a high incidence or risk of infection, e.g. operating theatres. The infection control policies must include the identification of these sites and the collection of specimens from them. The sites associated with the activities described in standard 8.2.1 are frequently included in such surveillance activities. Those individuals who collect specimens must be trained in the proper collection and handling of microbiological specimens.

Criteria

8.3.1.1 The hospital identifies those environmental sites from which specimens are to be collected.

8.3.1.2 The hospital identifies the frequency with which specimens are collected.

8.3.1.3 Procedures which describe how specimens are taken and sent to the laboratory, and action to be taken when laboratory reports identify pathogenic organisms, are implemented.

8.4 Infection control education for personnel

8.4.1 *The hospital provides education on infection control practices to personnel, patients and, when appropriate, family and other caregivers.*

Standard Intent
For a hospital to have effective infection control processes, personnel must be educated about these processes when they commence employment with the hospital and regularly thereafter. The education programme must include professional personnel and clinical and non-clinical support personnel.
Education provided should focus on the policies, procedures and practices that guide the hospital's infection control processes. It should also include findings and trends from the monitoring activities.
Education should be offered to patients, families and caregivers when appropriate.

Criteria

8.4.1.1 The hospital provides ongoing in-service training in infection control to all personnel.

8.4.1.2 Personnel are educated in infection control processes when new policies are implemented.

8.4.1.3 Personnel are provided with additional education in relevant aspects of the infection control processes when significant trends are noted in surveillance data.

8.4.1.4 Patients and families are educated when appropriate to the patient's needs and condition.

8.5 Infection control quality management

8.5.1 *The infection control processes are integrated with the hospital's processes for quality management and improvement.*

Standard Intent
The infection control system should be designed to reduce the risk of infection for patients, personnel and others. To reach this goal, the hospital must proactively monitor and track risks, rates and trends in healthcare-associated infections. The hospital should use the monitoring information to improve infection prevention and control activities and to reduce healthcare-associated infection rates to the lowest possible levels. This is best achieved by comparing infection rates and trends with data from other similar hospitals.
For the purpose of this section, please take note of the quality management and improvement methodology as described in Service Element 7.

This section contains the root criteria for those listed in all clinical Service Elements, such as 9.10.1.1. In other words, the latter cannot be scored compliant unless this section has achieved compliance.

Criteria

8.5.1.1 The hospital tracks infection risks, infection rates and trends in healthcare-associated infections.

8.5.1.2 Monitoring includes the use of indicators related to infections that are epidemiologically important to the hospital.

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

8.5.1.4 The hospital compares its infection rates with other hospitals through comparative databases.

8.5.1.5 The results of infection monitoring in the hospital are regularly communicated to medical and nursing personnel and to the management of the hospital.

8.5.1.6 The hospital reports information on infections to appropriate external public health agencies.

9 General Medical/Surgical/Paediatric and Obstetric Care

OVERVIEW OF GENERAL MEDICAL/SURGICAL/PAEDIATRIC AND OBSTETRIC CARE

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow-up.

These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel, among others. Each member of the team has a clear role to play in the patient's package of care services which is determined by their particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team.

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

Continuity of care:
From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers. Throughout all phases of care, patient needs must be matched with appropriate resources both within and, when necessary, outside the hospital. Transfers to and from specialised units, such as care and the operating theatre, must be in accordance with criteria that determine the appropriateness of such transfers.

Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively, implemented by all clinical personnel and monitored by the leaders of the various settings and services to ensure coordination of care.

9.1 Facilities and Equipment

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

Standard Intent

In order to provide safe patient care, each service requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment should be safely stored in a room or cupboard used for this purpose only. No cleaning equipment should be stored in areas where clean linen, medical supplies or food are stored. There should be adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation.

Adequate lighting and ventilation must be provided.

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

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

Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes as a minimum:

- An ECG monitor
- A CPR board (if required)
- Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- A bag-mask manual ventilator
- A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
- An introducer/stylet for endotracheal intubation
- A syringe to inflate the endotracheal tube cuff
- Oropharyngeal tubes
- Equipment to perform an emergency cricothyroidotomy – (needle and surgical)
- Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
- Drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
- A defibrillator or automated external defibrillator (AED) with adult paddles/pads (and infant paddles/pads where applicable) within three minutes of any patient collapsing

Criteria

9.1.1.1 Patient and personnel accommodation and equipment in the service are adequate to meet patient care needs.

9.1.1.2 Oxygen and vacuum supplies meet patient care requirements.

9.1.1.3 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

9.1.1.4 There is evidence that equipment is maintained in accordance with hospital policy.

9.1.1.5 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

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

9.1.1.7 There are isolation rooms available which comply with the minimum requirements for isolation.

9.1.1.8 Electricity and water are available in accordance with the hospital's arrangements.

9.1.2 *Specific resources are available for the provision of safe care to patients in the obstetric and maternity unit/ward.*

Standard Intent

Professional guidelines for obstetric/maternity care services recommend the personnel and resources required to manage the service safely. The personnel in the ward should be in possession of these guidelines and ensure that the recommendations are implemented. These guidelines provide norms for staffing an obstetric/maternity care unit, and also for the services and facilities required.

Each delivery room must have at least:

- One cardiotocograph machine
- An infant warming and resuscitation cart
- An incubator with adjustable temperature and separate oxygen supply
- A foetal monitor
- Equipment for inhalation analgesia

There should be a temperature-controlled nursery which has:

- Suitable bassinettes
- Photo-therapy lights
- A panel for viewing babies

Criteria

9.1.2.1 Current guidelines for the provision of obstetric/maternity care services and facilities are followed.

9.1.2.2 Staffing of the service complies with accepted staffing norms for obstetric/maternity care services.

9.1.2.3 Available medical equipment complies with accepted norms for obstetric/maternity care services.

9.1.2.4 Where resuscitation, intensive care, life support or obstetric/maternity monitoring equipment is used that does not have built-in battery backup units, there is an uninterruptible power supply (UPS) that complies with relevant requirements and is regularly serviced and tested.

9.1.2.5 Security measures are adequate to safeguard newborns, including identification of newborns and restricted access and exit monitoring in wards.

9.1.3 *Specific resources are available for the provision of safe care to patients in the paediatric ward.*

Standard Intent

Patient safety and risk minimisation initiatives must address the special needs of children. The prevention of injuries is an important consideration and must include measures to prevent at least falls, entrapment in beds and cribs, choking, strangulation and electrocution.

Treatment protocols and medication management relevant to children are addressed in the relevant sections of these standards.

Criteria

9.1.3.1 Security measures are adequate to safeguard paediatric patients, including identification of children and restricted access and exit monitoring in wards.

9.1.3.2 Single rooms are available that are large enough to accommodate parents/guardians who choose to stay with their children.

9.1.3.3 There are isolation rooms available which comply with the minimum requirements for isolation.

9.1.3.4 A treatment room for patient assessment and procedures is provided separate from the other patients.

9.1.3.5 Window guards are fitted and/or opening potential is limited on all windows.

9.1.3.6 Electrical sockets are placed above child height and/or covered.

9.1.3.7 Door latches and locks are located above child height.

9.1.3.8 Floor surfaces are non-slippery and clear of clutter.

9.1.3.9 Safety gates have small openings to prevent children getting through or being trapped.

9.1.3.10 Restraining measures such as secure cot sides on cots and beds are used.

9.1.3.11 Appropriate padding is available for sharp edges on furniture and equipment.

9.1.3.12 Where play/education area/s are available, age appropriate furniture and equipment are provided.

9.1.4 *There is a dedicated area for the preparation of infant feeds.*

Standard Intent
Infant feeds should be prepared in a hygienically clean area with adequate provision for infection control measures. This dedicated area can be either a designated milk kitchen or a designated area in the ward kitchen. A sink with a double bowl and separate hand wash basin should be provided in either setting. A refrigerator for the exclusive use of milk feeds should be available with facilities provided for warming the feeds.

Criteria

9.1.4.1 Personnel working in the feed preparation area wear protective clothing such as gloves, masks and aprons.

9.1.4.2 Appropriate hand washing facilities are available in the feed preparation area with appropriate disinfectant solutions.

9.1.4.3 Appropriate facilities and equipment to clean and disinfect utensils in the feed preparation area are available and functional.

9.1.4.4 Information about disinfectant solutions and frequency of replacement in the feed preparation area is displayed.

9.1.4.5 There is clear signage of unauthorised entry on the door to limit people traffic.

9.1.4.6 The storage cupboard for baby formula is clearly marked and locked.

9.2 Service Management

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

Standard Intent
The individuals who bear overall responsibility for the patient's care or for a particular phase of care should be identified in a manner that is made known to patients and personnel.

Criteria

9.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

9.2.1.3 The individuals responsible for patient care are qualified.

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

9.2.1.5 The requirements of antenatal, labour and postnatal wards and nurseries are individually included in the staffing requirements.

9.2.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable*
9.2.3 *variation.*

Standard Intent
Clinical practice guidelines provide a means for improving quality and assist practitioners in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged, e.g. hepatitis E in a nonendemic area.

Guidelines are found in the literature under many names including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the clinical leaders and clinical practitioners before implementation. This will ensure that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines should be reviewed on a regular basis to ensure their continued relevance.

Criteria

9.2.3.1 Evidence-based clinical practice guidelines relevant to the patients and services of the hospital are available to guide patient care processes.

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

9.2.3.3 Guidelines are reviewed on a regular basis and updated when necessary.

9.2.4 *Policies and procedures guide the care of high risk patients and the provision of high risk services.*

Standard Intent
Some patients are considered high risk because of their age, condition or the nature of their needs. Children and the frail or infirm elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or semi-comatose patient may be unable to understand the care process. In addition, the care required by these patients may need to be provided efficiently and rapidly.

High risk procedures are those associated with a relatively high rate of patient safety incidents and which have potentially severe complications. Examples of high risk patients and procedures include (where applicable):

- The care of emergency patients
- The handling, use and administration of blood and blood products
- The care of patients who are comatose
- The care of patients with communicable diseases
- The care of immuno-suppressed patients
- The care of patients on chemotherapy and radiotherapy
- The care of patients on dialysis
- The use of restraint and the care of patients in restraint
- The care of frail, dependent patients of any age

The clinical and managerial leaders should take responsibility for:
The identification of those patients and services considered as high risk
The development of documented protocols or standard operating procedures to treat high risk patients or carry out high risk procedures, which should be developed in collaboration with all relevant personnel to ensure competent and consistent care
Training of personnel in the implementation of these agreed documented protocols or standard operating procedures
Clinical guidelines should be consulted in the formulation of these documents to ensure that the care provided in these situations is in accordance with current best practice, including the clinical decision to perform high risk procedures and the method for performing these procedures. Implementation of these documented protocols and standard operating procedures should be monitored to ensure that the required standards of care are met for all relevant patients and services.

Criteria

9.2.4.1 Documented protocols, clinical guidelines or standard operating procedures for identified high risk patients and procedures, which include items (a)-(i) in the standard intent above as a minimum, are available and readily accessible.

9.2.4.2 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

9.3 Assessment of Patients

9.3.1 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent
When a patient enters a ward, the specific information required and the procedures for obtaining and documenting this information depend on the patient's needs and the setting in which care is being provided.
Documented hospital policy should define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations. These findings should be used throughout the care process to evaluate the patient's clinical progress and understand the need for reassessment. It is essential that assessments are documented comprehensively and can be easily retrieved from the patient's record.

Hospital policy should determine the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the hospital.

Criteria

9.3.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

9.3.1.4 Assessments are performed within appropriate time frames and are comprehensively documented in the patients' records according to hospital policy.

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

Standard Intent

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

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

Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. When appropriate, the assessment process should be modified to respect local cultural practices.

The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge should be commenced during this initial assessment process.

When the medical assessment was conducted by a different healthcare organisation, a legible copy of the findings should be filed in the patient's record. Any significant changes in the patient's condition since this assessment should be recorded.

Criteria

9.3.2.1 Each patient admitted has an initial assessment according to hospital policy.

9.3.2.2 The initial assessment includes health history.

9.3.2.3 The initial assessment includes physical examination.

9.3.2.4 The initial assessment includes functional and nutritional examination, where applicable.

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

9.3.2.6 The initial assessment includes psychological assessment, where applicable.

9.3.2.7 The initial assessment includes cultural assessment, where applicable.

9.3.2.8 The initial assessment results in an initial diagnosis.

9.3.2.9 The patient's medical, nursing and other healthcare needs identified during the initial assessment are documented.

9.3.3 *Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.*

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

Criteria

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

9.3.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care and used to develop the treatment plan, which includes the goals of care.

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

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

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

Standard Intent
The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy. Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.
The patient, family and others must be included in the decision-making process when appropriate.

The patient's record must contain a history of all care provided by the multidisciplinary team and be made available to all relevant caregivers who are authorised to access its content.

Criteria

9.3.4.1 The patient's clinical records are completed according to hospital policy.

9.3.4.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

9.3.4.3 Information exchanged includes a summary of the care provided.

9.3.4.4 Information exchanged includes the patient's progress.

9.3.4.5 Information exchanged includes the patient's progress.

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

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

9.4 Patient Care

9.4.1 *The care provided to each patient is planned and documented in the patient's record.*

Standard Intent
A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional. The care plan should include the care to be delivered and the intended goals of care. Collaborative care and treatment team meetings or similar patient discussions must be recorded.

Diagnostic and other procedures must be ordered by individuals qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders. The reason for requesting diagnostic imaging or laboratory tests should be recorded if this reason will be required for interpretation of the results.

The hospital must decide:

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

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients or visitors and verbal orders, including those given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

9.4.1.1 The planned care is provided and documented in the patient's record.

9.4.1.2 The patient's response to care and therapeutic interventions is documented in the patient record.

9.4.1.3 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

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

9.4.1.5 Re-assessments are performed at appropriate, regular intervals and following a change in the patient's condition and documented in the patient's record.

9.4.1.6 Care plans are revised when necessary in response to the findings of re-assessments.

9.4.2 *Each healthcare professional supports patient, family and caregiver participation in care decisions and care processes.*

Standard Intent

The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations.

Personnel involved in patient, family and caregiver education should collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective.

Education should be focused on the specific knowledge and skills that the patient, family members and caregivers will require to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.

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

Information relating to the planning and delivery of education should be recorded in a consistent location in the patient record and follow a standardised format.

Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

9.4.2.1 Patients and families indicate that they have received health education appropriate to their condition.

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

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

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

9.4.3 *Adequate information is provided when obtaining informed consent from patients or their legal representatives.*

Standard Intent

Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.

The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

- Discussion of the patient's diagnosis and why the procedure is advised
- The expected benefits of the procedure
- The likelihood of success of the procedure
- A thorough explanation of the proposed procedure
- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure

- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent
- How to obtain consent if the patient is unable to give consent due to age, diminished mentalcapacity (e.g. delirium, learning difficulties, etc.) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.

The leaders must agree and implement a process for the documentation of verbal consent.

Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.

Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements.

Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure. Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure.

Where permissible according to Namibian legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

9.4.3.1 There is a documented process for obtaining or confirming informed consent.

9.4.3.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

9.4.3.3 Verbal consent is obtained and recorded according to hospital policy.

9.4.4 *Pre-and post-procedural assessments are documented.*

Standard Intent

Medical care may include invasive procedures related to the medical condition, such as cardiac catheterisation and other interventional radiological procedures, endoscopy, biopsy, etc. The management of these interventions is considered in this section of the standards.

The pre-anaesthetic medical assessment determines whether the patient's medical condition is stable enough to allow for surgical intervention or the planned procedure and may significantly influence the pre- and intra-procedural management of the patient. All information regarding the medical assessment, investigation, treatment and review of the patient must be available to the doctor performing the pre-anaesthetic medical assessment.

A patient's post-procedural care at ward level is related to the procedure and the findings of the procedure. The report of the procedure must be available within an acceptable time frame to provide post-procedural care to the patient.

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

Criteria

9.4.4.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

9.4.4.2 Patients have a pre-procedural diagnosis recorded before anaesthesia.

9.4.4.3 A post-procedural diagnosis is documented.

9.4.4.4 The name of the medical practitioner responsible for the procedure is documented.

9.4.4.5 The patient's physiological status is monitored during the post-procedural period.

9.4.5 *The hospital implements processes to support the patient in managing pain.*

Standard Intent

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

To ensure that this right is implemented, the hospital should develop processes to:

- Identify patients in pain during the initial assessment and subsequent reassessments - communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

9.4.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

9.4.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

9.4.6 *The hospital develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully understand the reasons why specific decisions are taken. To accomplish this, all personnel must be

made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:
(a) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
(b) Sensitively addressing issues such as autopsy and organ donation
(c) Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care where appropriate
(d) Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs.

Criteria

9.4.6.1 Policies and procedures regarding end-of-life care, which include (a)-(d) in the standard intent above as a minimum, are implemented.

9.4.6.2 The patient, family and significant other(s) are involved in care decisions.

9.4.6.3 Pain and primary or secondary symptoms are managed according to hospital policy.

9.4.6.4 Religious and cultural needs of patients and their families or significant others are identified and met.

9.5 Medication Management

9.5.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication.
The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards.
Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian legal requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction.

"Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable.

There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary.
Doors, hinges and seals must all be functional.

Criteria

9.5.1.1 Medication is ordered according to hospital policy.

9.5.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

9.5.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

9.5.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

9.5.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

9.5.1.7 Medication is stored in a clean environment.

9.5.1.8 A dedicated refrigerator is available for medication requiring storage at low temperatures.

9.5.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

9.5.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

9.5.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

9.5.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

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

Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.

The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters, etc.

Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant. The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed.

In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

9.5.2.1 Policies and procedures that guide the safe prescribing and administration of medication are implemented.

9.5.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

9.5.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

9.5.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

9.5.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

9.5.2.6 There is evidence that patients are identified before medication is administered.

9.5.2.7 Medication is checked against the original prescriptions and administered as prescribed.

9.5.2.8 The medication prescribed for and administered to each patient is recorded.

9.5.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

9.5.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

9.5.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

9.6 Food and Nutrition Therapy

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

Standard Intent
A qualified caregiver should order appropriate food or other nutritional substitutes. The patient should participate in planning and selecting food. The patient's family may participate in providing food when appropriate. When they do, they should be educated as to which foods are contraindicated in the patient's clinical condition and potential interactions between certain foods and medication where relevant.

When possible, patients should be offered a variety of food choices consistent with their nutritional status. The nutritional status of patients must be monitored.

Criteria

9.6.1.1 Food appropriate to the patient is regularly available.

9.6.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

9.6.1.3 Wherever possible, patient food preferences are respected and substitutions made available.

9.6.1.4 When families provide food, they are educated about the patient's dietary limitations.

9.6.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

9.6.1.7 Nutrition therapy provided, whether oral, enteral or parenteral, is documented in the patient's record.

9.6.1.8 Response to nutrition therapy is monitored and recorded.

9.7 Continuity of Care

9.7.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent
As patients move through a healthcare organisation from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and

commission are more likely to occur, exposing the patient to avoidable risks. The hospital should therefore document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

9.7.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

9.7.1.2 Individuals responsible for the patient's care and its coordination are identified for all phases of patient care.

9.7.1.3 Continuity and coordination are evident throughout all phases of patient care.

9.7.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

9.7.1.5 Patient handover between healthcare professionals is standardised according to hospital policy.

9.7.2 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent

Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, access more extensive diagnostic evaluations than may be available locally, or access specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare organisation only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral organisation) or while under the care of the outpatient department. Hospital policy must clearly describe this referral process.

Criteria

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

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

9.7.2.3 Follow-up care based on the findings of investigations and/or consultations performed outside the referring hospital is documented in the patient record.

9.7.3 *There is a process to transfer patients to another organisation to meet their continuing needs.*

Standard Intent

This standard refers to the process by which a patient is discharged from the transferring hospital and handed over to receive ongoing care at another healthcare organisation.

Transfer may be to a higher level of care for specialised consultation and/or treatment, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient.

Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer. The process for transferring the patient must consider transportation needs as well as clinical needs.

Criteria

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

9.7.3.2 When a patient is transferred to another healthcare organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions performed by the referring (transferring) hospital.

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

9.7.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

9.7.4 *There is an organised process to discharge patients.*

Standard Intent

Care planning should include arrangements to meet the patients' continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability. At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The discharge summary must contain the following content as a minimum:

a) The diagnosis of main and significant illnesses
b) The results of investigations that will influence further management
c) All procedures performed
d) The patient's condition at discharge
e) Discharge medication
f) Follow-up arrangements where appropriate, including emergency review.

Criteria

9.7.4.1 There is a documented process to discharge patients.

9.7.4.2 Where the initial assessment indicates that discharge planning will be required, planning requirements are included in the patient's care plan and completed as scheduled.

9.7.4.3 The hospital works with the family, caregivers, healthcare practitioners and agencies outside the hospital to ensure timely and appropriate discharge.

9.7.4.4 Patients and where appropriate their families or caregivers are given understandable follow-up instructions which are documented in the patient's record.

9.7.4.5 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

9.7.4.6 Each record contains a copy of the discharge summary.

9.8 Quality Improvement

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

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team is responsible for ensuring that standards are set throughout the hospital. Within each department or service, unit managers should ensure that standards are set for the particular unit.

Departmental or service managers should use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structures to ensure coordinated quality improvement activities throughout the hospital. Quality monitoring is typically applied to high risk, high volume or high cost activities, or areas of concern identified by personnel, patients or visitors.

Some examples of activities that may benefit from quality monitoring include:

- Patient assessment
- Procedures carried out
- The use of antibiotics and other medication
- Medication errors
- The use of blood and blood products
- Patient and family expectations and satisfaction

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC.
Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, e.g. monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

9.8.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

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

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

9.8.1.4 A documentation audit system is in place.

9.9 Patient Rights

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

Standard Intent
This refers to the implementation of hospital policy on patient and family rights (Service Element 4).Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

9.9.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

9.10 Prevention and Control of Infection

9.10.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital policy for infection prevention and control (Service Element 8).

Criteria

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

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

9.10.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

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

9.10.1.8 Infection control processes include safe injection practices, including single-use injection devices.

9.10.1.9 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

9.11 Risk Management

9.11.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

9.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

9.11.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

9.11.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

9.11.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

9.11.1.5 Fire safety measures are implemented.

9.11.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

10 Medical Care

OVERVIEW OF MEDICAL CARE

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow-up.

These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel, among others. Each member of the team has a clear role to play in the patient's package of care services which is determined by their particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team.

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

Continuity of care:
From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers. Throughout all phases of care, patient needs must be matched with appropriate resources both within and, when necessary, outside the hospital. Transfers to and from specialised units, such as critical care and the operating theatre, must be in accordance with criteria that determine the appropriateness of such transfers.

Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively, implemented by all clinical personnel and monitored by the leaders of the various settings and services to ensure coordination of care.

10.1 Facilities and Equipment

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

Standard Intent

In order to provide safe patient care, each service requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment should be safely stored in a room or cupboard used for this purpose only. No cleaning equipment should be stored in areas where clean linen, medical supplies or food are stored. There should be adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation. Adequate lighting and ventilation must be provided. Nurse call systems should be available at bedsides and in bathrooms and toilets and connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, mobile oxygen cylinders and vacuum pumps must be available. All necessary fittings for oxygen and suction must be in place and functioning

satisfactorily. Each ward must be provided with a socket outlet that is connected to the emergency power supply.

Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes as a minimum:

a) An ECG monitor
b) A CPR board (if required)
c) Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
d) d) A bag-mask manual ventilator
e) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) An introducer/stylet for endotracheal intubation
g) A syringe to inflate the endotracheal tube cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
k) Drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)

A defibrillator or automated external defibrillator (AED) with adult paddles/pads (and infant paddles/pads where applicable) within three minutes of any patient collapsing

Criteria

10.1.1.1 Patient and personnel accommodation and equipment in the service are adequate to meet patient care needs.

10.1.1.2 Oxygen and vacuum supplies meet patient care requirements.

10.1.1.3 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

10.1.1.4 There is evidence that equipment is maintained in accordance with hospital policy.

10.1.1.5 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

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

10.1.1.7 There are isolation rooms available which comply with the minimum requirements for isolation.

10.1.1.8 Electricity and water are available in accordance with the hospital's arrangements.

10.2 Service Management

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

Standard Intent

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

10.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

10.2.1.3 The individuals responsible for patient care are qualified.

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

10.2.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable variation.*

Standard Intent
Clinical practice guidelines provide a means for improving quality and assist practitioners in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged, e.g. hepatitis E in a non-endemic area.

Guidelines are found in the literature under many names including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the clinical leaders and clinical practitioners before implementation. This will ensure that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines should be reviewed on a regular basis to ensure their continued relevance.

Criteria

10.2.2.1 Evidence-based clinical practice guidelines relevant to the patients and services of the hospital are available to guide patient care processes.

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

10.2.2.3 Guidelines are reviewed on a regular basis and updated when necessary.

10.2.3 *Policies and procedures guide the care of high risk patients and the provision of high risk services.*

Standard Intent
Some patients are considered high risk because of their age, condition or the critical nature of their needs. Children and the frail or infirm elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or semi-comatose patient may be unable to understand the care process. In addition, the care required by these patients may need to be provided efficiently and rapidly. High risk procedures are those associated with a relatively high rate of patient safety incidents and which have potentially severe complications.
Examples of high risk patients and procedures include (where applicable):

- The care of emergency patients
- The handling, use and administration of blood and blood products
- The care of patients who are comatose

- The care of patients with communicable diseases
- The care of immuno-suppressed patients
- The care of patients on chemotherapy and radiotherapy
- The care of patients on dialysis
- The use of restraint and the care of patients in restraint
- The care of frail, dependent patients of any age

The clinical and managerial leaders should take responsibility for:

a) The identification of those patients and services considered as high risk
   - The development of documented protocols or standard operating procedures to treat high risk patients or carry out high risk procedures, which should be developed in collaboration with all relevant personnel to ensure competent and consistent care
   - Training of personnel in the implementation of these agreed documented protocols or standard operating procedures

Clinical guidelines should be consulted in the formulation of these documents to ensure that the care provided in these situations is in accordance with current best practice, including the clinical decision to perform high risk procedures and the method for performing these procedures.
Implementation of these documented protocols and standard operating procedures should be monitored to ensure that the required standards of care are met for all relevant patients and services.

Criteria

10.2.3.1 Documented protocols, clinical guidelines or standard operating procedures for identified high risk patients and procedures, which include items (a)-(i) in the standard intent above as a minimum, are available and readily accessible.

10.2.3.2 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

10.3 Assessment of Patients

10.3.1 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

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

Documented hospital policy should define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations. These findings should be used throughout the care process to evaluate the patient's clinical progress and understand the need for reassessment. It is essential that assessments are documented comprehensively and can be easily retrieved from the patient's record.

Hospital policy should determine the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the hospital.

Criteria

10.3.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

10.3.1.4 Assessments are performed within appropriate time frames and are comprehensively documented in the patient's records according to hospital policy.

10.3.2 *Each patient' s has an initial assessment that complies with current policies, procedures and guidelines.*

Standard Intent

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

Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. When appropriate, the assessment process should be modified to respect local cultural practices.

The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge should be commenced during this initial assessment process.

When the medical assessment was conducted by a different healthcare organisation, a legible copy of the findings should be filed in the patient's record. Any significant changes in the patient's condition since this assessment should be recorded.

Criteria

10.3.2.1 Each patient admitted has an initial assessment according to hospital policy.

10.3.2.2 The initial assessment includes health history.

10.3.2.3 The initial assessment includes physical examination.

10.3.2.4 The initial assessment includes functional and nutritional examination, where applicable.

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

10.3.2.6 The initial assessment includes psychological assessment, where applicable.

10.3.2.7 The initial assessment includes cultural assessment, where applicable.

10.3.2.8 The initial assessment results in an initial diagnosis.

10.3.2.9 The patient's medical, nursing and other healthcare needs identified during the initial assessment are documented.

10.3.3 *Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.*

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

Criteria

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

10.3.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care and used to develop the treatment plan, which includes the goals of care.

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

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

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

Standard Intent
The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy.

Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.

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

Criteria

10.3.4.1 The patients' clinical records are completed according to hospital policy.

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

10.3.4.3 Information exchanged includes a summary of the care provided.

10.3.4.4 Information exchanged includes the patient's progress.

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

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

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

10.4 Patient Care

10.4.1 *The care provided to each patient is planned and documented in the patient's record.*

Standard Intent
A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional. The care plan should include the care to be delivered and the intended goals of care. Collaborative care and treatment team meetings or similar patient discussions must be recorded.

Diagnostic and other procedures must be ordered by individuals qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders. The reason for requesting diagnostic imaging or laboratory tests should be recorded if this reason will be required for interpretation of the results.

The hospital must decide:
a) Which orders must be written rather than verbal
   - Who is permitted to write orders
   - Where orders are to be located in the patient record

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients or visitors and verbal orders, including those given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

10.4.1.1 The planned care is provided and documented in the patient's record.

10.4.1.2 The patient's response to care and therapeutic interventions is documented in the patient record.

10.4.1.3 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

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

10.4.1.5 Re-assessments are performed at appropriate, regular intervals and following a change in the patient's condition and documented in the patient's record.

10.4.1.6 Care plans are revised when necessary in response to the findings of re-assessments.

10.4.2 *Each healthcare professional supports patient, family and caregiver participation in care decisions and care processes.*

Standard Intent
The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations.

Personnel involved in patient, family and caregiver education should collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective.

Education should be focused on the specific knowledge and skills that the patient, family members and caregivers will require to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.

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

Information relating to the planning and delivery of education should be recorded in a consistent location in the patient record and follow a standardised format.

Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

10.4.2.1 Patients and families indicate that they have received health education appropriate to their condition.

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

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

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

10.4.3 *Adequate information is provided when obtaining informed consent from patients or their legal representatives.*

Standard Intent
Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.
The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

a) Discussion of the patient's diagnosis and why the procedure is advised
   - The expected benefits of the procedure
   - The likelihood of success of the procedure
   - A thorough explanation of the proposed procedure

- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure
- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent - How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g. delirium, learning difficulties, etc.) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.
The leaders must agree and implement a process for the documentation of verbal consent. Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.
Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements. Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure.

Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. Where permissible according to country-specific legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

10.4.3.1 There is a documented process for obtaining or confirming informed consent.

10.4.3.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

10.4.3.3 Verbal consent is obtained and recorded according to hospital policy.

10.4.4 *Pre-and post-procedural assessments are documented.*

Standard Intent

Medical care may include invasive procedures related to the medical condition, such as cardiac catheterisation and other interventional radiological procedures, endoscopy, biopsy, etc. The management of these interventions is considered in this section of the standards.

The pre-anaesthetic medical assessment determines whether the patient's medical condition is stable enough to allow for surgical intervention or the planned procedure and may significantly influence the pre- and intra-procedural management of the patient. All information regarding the medical assessment, investigation, treatment and review of the patient must be available to the doctor performing the pre-anaesthetic medical assessment.

A patient's post-procedural care at ward level is related to the procedure and the findings of the procedure. The report of the procedure must be available within an acceptable time frame to provide post-procedural care to the patient.

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

Criteria

10.4.4.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

10.4.4.2 Patients have a pre-procedural diagnosis recorded before anaesthesia.

10.4.4.3 A post-procedural diagnosis is documented.

10.4.4.4 The name of the medical practitioner responsible for the procedure is documented.

10.4.4.5 The patient's physiological status is monitored during the post-procedural period.

10.4.5 *The hospital implements processes to support the patient in managing pain.*

Standard Intent

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

To ensure that this right is implemented, the hospital should develop processes to:

a) Identify patients in pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

10.4.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

10.4.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

10.4.6 *The hospital develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully

understand the reasons why specific decisions are taken. To accomplish this, all personnel must be made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:

a) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
   - Sensitively addressing issues such as autopsy and organ donation
   - Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care where appropriate
   - Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs

Criteria

10.4.6.1 Policies and procedures regarding end-of-life care, which include (a)-(d) in the standard intent above as a minimum, are implemented.

10.4.6.2 The patient, family and significant other(s) are involved in care decisions.

10.4.6.3 Pain and primary or secondary symptoms are managed according to hospital policy.

10.4.6.4 Religious and cultural needs of patients and their families or significant others are identified and met.

10.5 Medication Management

10.5.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards.

Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary. Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian legal requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction. "Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary.
Doors, hinges and seals must all be functional.

Criteria

10.5.1.1 Medication is ordered according to hospital policy.

10.5.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

10.5.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

10.5.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

10.5.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

10.5.1.7 Medication is stored in a clean environment.

10.5.1.8 A dedicated refrigerator is available for medication requiring storage at low temperatures.

10.5.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

10.5.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

10.5.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

10.5.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel should participate in a collaborative process to develop and monitor policies and procedures. Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.

The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters, etc. Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant. The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed.

In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

10.5.2.1 Policies and procedures that guide the safe prescribing and administration of medication are implemented.

10.5.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

10.5.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

10.5.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

10.5.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

10.5.2.6 There is evidence that patients are identified before medication is administered.

10.5.2.7 Medication is checked against the original prescriptions and administered as prescribed.

10.5.2.8 The medication prescribed for and administered to each patient is recorded.

10.5.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

10.5.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

10.5.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

10.6 Food and Nutrition Therapy

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

Standard Intent

A qualified caregiver should order appropriate food or other nutritional substitutes. The patient should participate in planning and selecting food. The patient's family may participate in providing food when appropriate. When they do, they should be educated as to which foods are contraindicated in the patient's clinical condition and potential interactions between certain foods and medication where relevant.

When possible, patients should be offered a variety of food choices consistent with their nutritional status.

The nutritional status of patients must be monitored.

Criteria

10.6.1.1 Food appropriate to the patient is regularly available.

10.6.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

10.6.1.3 Wherever possible, patient food preferences are respected, and substitutions made available.

10.6.1.4 When families provide food, they are educated about the patient's dietary limitations.

10.6.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

10.6.1.7 Nutrition therapy provided, whether oral, enteral or parenteral, is documented in the patient's record.

10.6.1.8 Response to nutrition therapy is monitored and recorded.

10.7 Continuity of Care

10.7.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent

As patients move through a healthcare organisation from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission are more likely to occur, exposing the patient to avoidable risks. The hospital should therefore document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

10.7.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

10.7.1.2 Individuals responsible for the patient's care and its coordination are identified for all phases of patient care.

10.7.1.3 Continuity and coordination are evident throughout all phases of patient care.

10.7.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

10.7.1.5 Patient handover between healthcare professionals is standardised according to hospital policy.

10.7.2 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent

Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, access more extensive diagnostic evaluations than may be available locally, or access specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare organisation only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral organisation) or while under the care of the outpatient department. Hospital policy must clearly describe this referral process.

Criteria

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

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

10.7.2.3 Follow-up care based on the findings of investigations and/or consultations performed outside the referring hospital is documented in the patient record.

10.7.3 *There is a process to transfer patients to another organisation to meet their continuing needs.*

Standard Intent

This standard refers to the process by which a patient is discharged from the transferring hospital and handed over to receive ongoing care at another healthcare organisation.

Transfer may be to a higher level of care for specialised consultation and/or treatment, or for less intensive services such as sub-acute care or long-term rehabilitation. To ensure continuity of care, adequate information must accompany the patient.

Transfer may be an uncomplicated process with the patient alert and talking or may involve continuous nursing or medical supervision. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer. The process for transferring the patient must consider transportation needs as well as clinical needs.

Criteria

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

10.7.3.2 When a patient is transferred to another organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions performed by the referring (transferring) hospital.

10.7.3.3 A copy of the transfer summary is available in the patient record

10.7.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

10.7.4 *There is an organised process to discharge patients.*

Standard Intent

Care planning should include arrangements to meet the patients' continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.

The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability. At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The discharge summary must contain the following content as a minimum:

a) The diagnosis of main and significant illnesses
- The results of investigations that will influence further management
- All procedures performed
- The patient's condition at discharge
- Discharge medication
- Follow-up arrangements where appropriate, including emergency review

Criteria

10.7.4.1 There is a documented process to discharge patients.

10.7.4.2 Where the initial assessment indicates that discharge planning will be required, planning requirements are included in the patient's care plan and completed as scheduled.

10.7.4.3 The hospital works with the family, caregivers, healthcare practitioners and agencies outside the hospital to ensure timely and appropriate discharge.

10.7.4.4 Patients and where appropriate their families or caregivers are given understandable follow-up instructions which are documented in the patient's record.

10.7.4.5 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

10.7.4.6 Each record contains a copy of the discharge summary.

10.8 Quality Improvement

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

Standard
This refers to the implementation of hospital quality improvement processes (Service Element 7).

The senior management team is responsible for ensuring that standards are set throughout the hospital. Within each department or service, unit managers should ensure that standards are set for the particular unit. Departmental or service managers should use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structures to ensure coordinated quality improvement activities throughout the hospital.
Quality monitoring is typically applied to high risk, high volume or high cost activities, or areas of concern identified by personnel, patients or visitors. Some examples of activities that may benefit from quality monitoring include:

a) Patient assessment
   - Procedures carried out
   - The use of antibiotics and other medication
   - Medication errors
   - The use of blood and blood products
   - Patient and family expectations and satisfaction

The following will be evaluated:
a) The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
   - The processes put in place to resolve the problems
   - The identification of indicators to measure improvement
   - The tool(s) used to evaluate these indicators
   - The monitoring of these indicators and corrective steps taken when goals were not achieved
   - Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC.
Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, e.g. monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

10.8.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

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

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

10.8.1.4 A documentation audit system is in place.

10.9 Patient Rights

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

Standard
This refers to the implementation of hospital policy on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

10.9.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

10.10 Prevention and Control of Infection

10.10.1 *The department/service implements infection prevention and control processes.*

Standard
This refers to the implementation of hospital policy for infection prevention and control (Service Element 8).

Criteria

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

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

10.10.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

10.10.1.7 Infection control processes include safe injection practices, including single-use injection devices.

10.10.1.8 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

10.11 Risk Management

10.11.1 *The department/service implements risk management processes.*

Standard
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

10.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

10.11.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

10.11.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

10.11.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

10.11.1.5 Fire safety measures are implemented.

10.11.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

11 Surgical Care

OVERVIEW OF SURGICAL CARE

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow-up.

These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel, among others. Each member of the team has a clear role to play in the patient's package of care services which is determined by their particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team.

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

Continuity of care:
From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers. Throughout all phases of care, patient needs must be matched with appropriate resources both within and, when necessary, outside the hospital. Transfers to and from specialised units, such as critical care and the operating theatre, must be in accordance with criteria that determine the appropriateness of such transfers.

Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively, implemented by all clinical personnel and monitored by the leaders of the various settings and services to ensure coordination of care.

Standards

11.1 Facilities and Equipment

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

Standard Intent

In order to provide safe patient care, each service requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment should be safely stored in a room or cupboard used for this purpose only. No cleaning equipment should be stored in areas where clean linen, medical supplies or food are stored. There must be adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation. Adequate lighting and ventilation must be provided. Nurse call systems must be available at bedsides and in bathrooms and toilets and connected to the emergency power supply.

Where there is no piped oxygen and vacuum supply, mobile oxygen cylinders and vacuum pumps must be available. All necessary fittings for oxygen and suction must be in place and functioning

satisfactorily. Each ward must be provided with a socket outlet that is connected to the emergency power supply.

Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes as a minimum:

a) An ECG monitor
b) A CPR board (if required)
c) Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
d) A bag-mask manual ventilator
e) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) An introducer/stylet for endotracheal intubation
g) A syringe to inflate the endotracheal tube cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
k) Drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
l) A defibrillator or automated external defibrillator (AED) with adult paddles/pads (and infant paddles/pads where applicable) within three minutes of any patient collapsing

Criteria

11.1.1.1 Patient and personnel accommodation and equipment in the service are adequate to meet patient care needs.

11.1.1.2 Oxygen and vacuum supplies meet patient care requirements.

11.1.1.3 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

11.1.1.4 There is evidence that equipment is maintained in accordance with the hospital policy.

11.1.1.5 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

11.1.1.6 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

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

11.1.1.8 There are isolation rooms available which comply with the minimum requirements for isolation.

11.1.1.9 Electricity and water are available in accordance with the hospital's arrangements.

11.2 Service Management

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

Standard Intent
The individuals who bear overall responsibility for the patient's care or for a particular phase of care should be identified in a manner that is made known to the personnel and patients.

Criteria

11.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

11.2.1.3 The individuals responsible for patient care are qualified.

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

11.2.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable variation.*

Standard Intent
Clinical practice guidelines provide a means for improving quality and assist practitioners in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume, high cost and problem-prone conditions as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged, e.g. oesophageal perforation.

Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the clinical leaders and clinical practitioners before implementation. This will ensure that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines should be reviewed on a regular basis to ensure their continued relevance.

Criteria

11.2.2.1 Evidence-based clinical practice guidelines, relevant to the patients and services of the hospital, are available to guide patient care processes.

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

11.2.2.3 Guidelines are reviewed on a regular basis and updated when necessary.

11.2.3 *Policies and procedures guide the care of high risk patients and the provision of high risk services.*

Standard Intent
Some patients are considered high risk because of their age, condition or the critical nature of their needs. Children and the frail or infirm elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient may be unable to understand the care process. In addition, the care required by these patients may need to be provided efficiently and rapidly.
High risk procedures are those associated with a relatively high rate of patient safety incidents and which have potentially severe complications.

Examples of high risk patients and procedures include (where applicable):
a) The care of emergency patients
b) The handling, use and administration of blood and blood products
c) The care of patients who are comatose
d) The care of patients with communicable diseases
e) The care of immuno-suppressed patients
f) The care of patients on chemotherapy and radiotherapy
g) The care of patients on dialysis
h) The use of restraint and the care of patients in restraint
i) The care of frail, dependent patients of any age

The clinical and managerial leaders take responsibility for:
- The identification of those patients and services considered as high risk
- The development of documented protocols or standard operating procedures in collaboration with all relevant personnel to ensure competent and consistent care
- Training of personnel in the implementation of these agreed patient management procedures

Clinical guidelines should be consulted in the formulation of these documents to ensure that the care provided in these situations is in accordance with current best practice in relation to the care offered to high risk patients, the clinical decision to perform high risk procedures and the method of performing these procedures.
Monitoring implementation of these guidelines provides the necessary information to ensure that the required standards of care are met for all relevant patients and services.

Criteria

11.2.3.1 Documented protocols, clinical guidelines or standard operating procedures for identified high risk patients and procedures, which include items (a)-(i) in the standard intent above as a minimum, are available and readily accessible.

11.2.3.2 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

11.3 Assessment of Patients

11.3.1 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent
When a patient enters a ward, the specific information required and the procedures for obtaining and documenting this information depend on the patient's needs and on the setting in which care is being provided. Documented hospital policy must define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations. These findings should be used throughout the care process to evaluate patient progress and understand the need for reassessment. It is essential that assessments are documented well and can be easily retrieved from the patient's record.
Hospital policy must define the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings should be verified on admission to the hospital.

Criteria

11.3.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

11.3.1.4 Assessments are performed within appropriate time frames and are adequately documented in the patient's records according to hospital policy.

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

Intent of 11.3.2

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

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. When appropriate, the assessment process should be modified to respect local cultural practices.

The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge should be commenced during this initial assessment process.

When the medical assessment was conducted by a different healthcare organisation, a legible copy of the findings should be placed in the patient's record. Any significant changes in the patient's condition since this assessment should be recorded.

Criteria

11.3.2.1 Each patient admitted has an initial assessment according to hospital policy.

11.3.2.2 The initial assessment includes health history.

11.3.2.3 The initial assessment includes physical examination.

11.3.2.4 The initial assessment includes functional and nutritional examination, where applicable.

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

11.3.2.6 The initial assessment includes psychological assessment, where applicable.

11.3.2.7 The initial assessment includes cultural assessment, where applicable.

11.3.2.8 The initial assessment results in an initial diagnosis.

11.3.2.9 The patient's medical, nursing and other healthcare needs identified during the initial assessment are documented.

11.3.3 *Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.*

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

Criteria

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

11.3.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care to inform the treatment plan, which includes the goals of care.

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

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

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

Standard Intent
The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy. Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.

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

Criteria

11.3.4.1 The patient's clinical records are completed according to hospital policy.

11.3.4.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

11.3.4.3 Information exchanged includes a summary of the care provided.

11.3.4.4 Information exchanged includes the patient's progress.

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

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

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

11.4 Patient Care

11.4.1 *The care provided to each patient is planned and documented in the patient's record.*

Standard Intent
A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional. The care plan should include the care to be delivered and the intended goals of care.
Collaborative care and treatment team meetings or similar patient discussions should be recorded.
Diagnostic and other procedures must be ordered by individuals qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.
The reason for requesting diagnostic imaging or laboratory tests should be recorded if this reason will be required for interpretation of the results.

The hospital must decide:

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

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients or visitors and verbal orders, including those given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

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

11.4.1.2 The patient's response to care and therapeutic interventions is documented in the patient record.

11.4.1.3 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

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

11.4.1.5 Reassessments are performed at appropriate, regular intervals and following a change in the patient's condition and documented in the patient's record.

11.4.1.6 Care plans are revised when necessary in response to the findings of re-assessments.

11.4.2 *Each healthcare professional supports patient, family and caregiver participation in care decisions and care processes.*

Standard Intent
The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking in account factors such as educational literacy, cultural beliefs and personal limitations.
Personnel involved in patient, family and caregiver education must collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective. Education must

be focused on the specific knowledge and skills that the patient, family members and caregivers will need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.
It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to remain an inpatient rather than receiving care as an outpatient.
Information relating to the planning and delivery of education must be recorded in a consistent location in the patient record and follow a standardised format.
Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

11.4.2.1 Patients and families indicate that they have received health education appropriate to their condition.

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

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

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

11.4.3 *Adequate information is provided when obtaining informed consent from patients or their legal representatives.*

Standard Intent

Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.
The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

a) Discussion of the patient's diagnosis and why the procedure is advised
b) The expected benefits of the procedure
c) The likelihood of success of the procedure
d) A thorough explanation of the proposed procedure
e) The potential risks and complications of the procedure
f) A discussion of viable alternative options including risks and benefits
g) The potential risks of refusing the proposed procedure
h) Confirmation that the patient or their legal representative has understood the information provided
i) An opportunity for the patient or their legal representative to ask questions
j) Comprehensive documentation of the process followed to obtain informed consent
k) How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity, (e.g. delirium, learning difficulties, etc.) or by virtue of their physical illness, (e.g. comatose)
l) Documentation of the signature of the patient or their legal representative for written consent
m) Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.

The leaders must agree and implement a process for the documentation of verbal consent.
Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.

Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements. Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure. Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure.

Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. Where permissible according to Namibian legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

11.4.3.1 There is a documented process for obtaining or confirming informed consent.

11.4.3.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

11.4.3.3 Verbal consent is obtained and recorded according to hospital policy.

11.4.4 *Pre-and post-operative assessments are documented.*

Standard Intent
The pre-anaesthetic medical assessment determines whether the patient's medical condition is stable enough to allow for surgical intervention or the planned procedure and may significantly influence the pre- and intra-procedural management of the patient. All information regarding the medical assessment, investigation, treatment and review of the patient must be available to the doctor performing the pre-anaesthetic medical assessment. In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition.

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

A patient's post-procedural care at ward level is related to the procedure and the findings of the procedure. The report of the procedure must be available within an acceptable time frame to provide post-procedural care to the patient.

Results of monitoring influence intra- and post-procedural decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge. The term "procedure" refers to both minor and major surgical interventions.

Criteria

11.4.4.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

11.4.4.2 Patients have a pre-procedural diagnosis recorded before anaesthesia.

11.4.4.3 A post-procedural diagnosis is documented.

11.4.4.4 The name of the medical practitioner responsible for the procedure is documented.

11.4.4.5 The patient's physiological status is monitored during the post-procedural period.

11.4.5 *The hospital implements processes to support the patient in managing pain.*

Intent of 11.4.5
While pain may be part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain must be respected and supported.

To ensure that this right is implemented, the hospital should develop processes to:

- Identify patients with pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

11.4.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

11.4.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

11.4.6 *The hospital develops processes to manage end-of-life care.*

Standard Intent
Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully understand the reasons why specific decisions are taken.
To accomplish this, all personnel must be made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:

a) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) Sensitively addressing issues such as autopsy and organ donation
c) Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care where appropriate
d) Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs

Criteria

11.4.6.1 Policies and procedures regarding end-of-life care, which include (a)-(d) in the standard intent above

11.4.6.2 The patient, family and significant other(s) are involved in care decisions.

11.4.6.3 Pain and primary or secondary symptoms are managed according to hospital policy.

11.4.6.4 Religious and cultural needs of patients and their families or significant other(s) are identified and met.

11.5 Medication Management

11.5.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Intent of 11.5.1

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards. Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian legal requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction. "Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary. Doors, hinges and seals must all be functional.

Criteria

11.5.1.1 Medication is ordered according to hospital policy.

11.5.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

11.5.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

11.5.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

11.5.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

11.5.1.7 Medication is stored in a clean environment.

11.5.1.8 A dedicated refrigerator is available for those medication requiring storage at low temperatures.

11.5.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

11.5.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

11.5.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

11.5.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel should participate in a collaborative process to develop and monitor policies and procedures. Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.

The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheter, etc. Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant.

The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed.

In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

11.5.2.1 Policies and procedures that guide the safe prescribing and administration of medication are implemented.

11.5.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

11.5.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

11.5.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

11.5.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

11.5.2.6 There is evidence that patients are identified before medication is administered.

11.5.2.7 Medication is checked against the original prescriptions and administered as prescribed.

11.5.2.8 The medication prescribed for and administered to each patient are recorded.

11.5.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

11.5.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

11.5.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

11.6 Food and Nutrition Therapy

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

Standard Intent

A qualified caregiver should order appropriate food or other nutritional substitutes. The patient should participate in planning and selecting food. The patient's family may participate in providing food when appropriate. If so, they must be educated as to which food is contraindicated in the patient's clinical condition and potential interactions between certain food and medication where relevant.

When possible, patients should be offered a variety of food choices consistent with their nutritional status. The nutritional status of the patients is monitored.

Criteria

11.6.1.1 Food appropriate to the patient is regularly available.

11.6.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

11.6.1.3 Wherever possible, patient food preferences are respected and substitutions made available.

11.6.1.4 When families provide food, they are educated about the patient's dietary limitations.

11.6.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

11.6.1.7 Nutrition therapy provided, whether oral, enteral or parenteral, is written in the patient's record.

11.6.1.8 Response to nutrition therapy is monitored and recorded.

11.7 Continuity of Care

11.7.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent

As patients move through a healthcare organisation from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission are more likely to occur, exposing the patient to avoidable risks. The hospital should therefore document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

11.7.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

11.7.1.2 Individuals responsible for the patient’s care and its coordination are identified for all phases of patient care.

11.7.1.3 Continuity and coordination are evident throughout all phases of patient care.

11.7.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

11.7.1.5 Patient handover between healthcare professionals is standardised according to hospital policy.

11.7.2 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent
Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare facility only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral facility) or while under the care of the outpatient department.
hospital policy must clearly describe this referral process.

Criteria

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

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

11.7.2.3 Follow-up care based on the findings of investigations and/or consultations performed outside the referring hospital is documented in the patient record.

11.7.3 *There is a process to transfer patients to another organisation to meet their continuing needs.*

Standard Intent
This standard refers to the process by which a patient is discharged from the transferring hospital and handed over to receive ongoing care at another healthcare organisation, i.e. the facility receiving the transferred patient. Transfer may be to a higher level of care for specialised treatment, or for less intensive services such as subacute care or long-term rehabilitation. To ensure continuity of care, adequate information must accompany the patient.
Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs as well as clinical needs. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer.

Criteria

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

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

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

11.7.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

11.7.4 *There is an organised process to discharge patients.*

Standard Intent

Care planning should include arrangements to meet the patients' continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing. The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.
At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The discharge summary must contain the following content as a minimum:
a) The diagnosis of main and significant illnesses
b) The results of investigations that will influence further management
c) All procedures performed
d) The patient's condition at discharge
e) Discharge medication
f) Follow-up arrangements where appropriate, including emergency review

Criteria

11.7.4.1 There is a documented process to discharge patients.

11.7.4.2 Where the initial assessment indicates that discharge planning will be required, planning requirements are included in the patient's care plan and completed as scheduled.

11.7.4.3 The hospital works with the family, caregivers, healthcare practitioners and agencies outside the hospital to ensure timely and appropriate discharge.

11.7.4.4 Patients and where appropriate their families or caregivers are given understandable follow-up instructions which are documented in the patient's record.

11.7.4.5 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

11.7.4.6 Each record contains a copy of the discharge summary.

11.8 Quality Improvement

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

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team is responsible for ensuring that standards are set throughout the hospital. Within each department or service, unit managers must ensure that standards are set for the particular unit. Departmental or service managers must use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structures to ensure coordinated quality improvement activities throughout the hospital.
Quality monitoring is typically applied to high risk, high volume or high cost activities, or areas of concern identified by personnel, patients or visitors.

Some examples of activities that may benefit from quality monitoring include:

- Patient assessment
- Procedures carried out
- The use of antibiotics and other medication
- Medication errors
- The use of blood and blood products
- Patient and family expectations and satisfaction. The following will be evaluated:
- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, e.g. monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

11.8.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

11.8.1.2

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

11.8.1.4

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

11.8.1.6

11.8.1.7 A documentation audit system is in place.

11.9 Patient Rights

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

Standard Intent

This refers to the implementation of hospital policy on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

11.9.1.2

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

11.9.1.4

11.9.1.5 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

11.10 Prevention and Control of Infection

11.10.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital systems for infection prevention and control (Service Element 8).

Criteria

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

11.10.1.2

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

11.10.1.4

11.10.1.5 Personnel are trained in correct hand washing procedures.

11.10.1.6

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

11.10.1.8

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

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

11.10.1.11

11.10.1.12 Infection control processes include safe injection practices, including single-use injection devices.

11.10.1.13

11.10.1.14 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

11.11 Risk Management

11.11.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

11.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

11.11.1.2

11.11.1.3 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

11.11.1.4

11.11.1.5 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

11.11.1.6

11.11.1.7 Security measures are implemented to ensure the safety of patients, personnel and visitors.

11.11.1.8

11.11.1.9 Fire safety measures are implemented.

11.11.1.10

11.11.1.11 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

12 Paediatric Care

OVERVIEW OF PAEDIATRIC CARE

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow-up.

These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel, among others. Each member of the team has a clear role to play in the patient's package of care services which is determined by their particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team.

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

Continuity of care:
From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers. Throughout all phases of care, patient needs must be matched with appropriate resources both within and, when necessary, outside the hospital. Transfers to and from specialised units, such as critical care and the operating theatre, must be in accordance with criteria that determine the appropriateness of such transfers. Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively, implemented by all clinical personnel and monitored by the leaders of the various settings and services to ensure coordination of care.

Standards

12.1 Facilities and Equipment

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

Standard Intent

In order to provide safe patient care, each service requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. No cleaning equipment should be stored in areas where clean linen, medical supplies or food are stored. There must be adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation. Adequate lighting and ventilation must be provided. Nurse call systems must be available at bedsides and in bathrooms and toilets and connected to the emergency power supply.

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

Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes as a minimum:

a) An ECG monitor
b) A CPR board (if required)
c) Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
d) A bag-mask manual ventilator
e) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) An introducer/stylet for endotracheal intubation
g) A syringe to inflate the endotracheal tube cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (paediatric sizes)
k) Drugs for cardiac arrest, coma, seizures and states of shock (paediatric doses)
l) A defibrillator or automated external defibrillator (AED) with infant and paediatric paddles/pads within three minutes of any patient collapsing

Criteria

12.1.1.1 Patient and personnel accommodation and equipment in the service are adequate to meet patient care needs.

12.1.1.2

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

12.1.1.4

12.1.1.5 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

12.1.1.6 There is evidence that equipment is maintained in accordance with the hospital policy.

12.1.1.7

12.1.1.8 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

12.1.1.9

12.1.1.10 Each patient of suitable age or their caregiver has access to a nurse call system at all times.

12.1.1.11

12.1.1.12 Electricity and water are available in accordance with the hospital's arrangements.

12.1.2 *Specific resources are available for the provision of safe care to patients in the paediatric ward.*

Standard Intent

Patient safety and risk minimisation initiatives must address the special needs of children. The prevention of injuries is an important consideration and must include measures to prevent at least falls, entrapment in beds and cribs, choking, strangulation and electrocution. Treatment protocols and medication management relevant to children are addressed in the relevant sections of these standards.

Criteria

12.1.2.1 Security measures are adequate to safeguard paediatric patients, including identification of children and restricted access and exit monitoring in wards.

12.1.2.2 Single rooms are available that are large enough to accommodate parents/guardians who choose to stay with their children.

12.1.2.3 There are isolation rooms available which comply with the minimum requirements for isolation.

12.1.2.4 A treatment room for patient assessment and procedures is provided separate from the other patients.

12.1.2.5 Window guards are fitted and/or opening potential is limited on all windows.

12.1.2.6 Electrical sockets are placed above child height and/or covered.

12.1.2.7 Door latches and locks are located above child height.

12.1.2.8 Floor surfaces are non-slippery and clear of clutter.

12.1.2.9 Safety gates have small openings to prevent children getting through or being trapped.

12.1.2.10 Restraining measures such as secure cot sides available on cots and beds are used.

12.1.2.11 Appropriate padding is available for sharp edges on furniture and equipment.

12.1.2.12 Where play/education area/s are available, age appropriate furniture and equipment are provided.

12.1.3 *There is a dedicated area for the preparation of infant feeds.*

Standard Intent

Infant feeds should be prepared in a hygienically clean area with adequate provision for infection control measures. This dedicated area can be either a designated milk kitchen or a designated area in the ward kitchen. A sink with a double bowl and separate hand wash basin should be provided in either setting. A refrigerator for the exclusive use of milk feeds should be available with facilities provided for warming the feeds.

Criteria

12.1.3.1 Personnel working in the feed preparation area wear protective clothing such as gloves, masks and aprons.

12.1.3.2 Appropriate hand washing facilities are available in the feed preparation area with appropriate disinfectant solutions.

12.1.3.3 Appropriate facilities and equipment to clean and disinfect utensils in the feed preparation area are available and functional.

12.1.3.4 Information about disinfectant solutions and frequency of replacement in the feed preparation area is displayed.

12.1.3.5 There is clear signage of unauthorised entry on the door to limit people traffic.

12.1.3.6 The storage cupboard for baby formula is clearly marked and locked.

12.2 Service Management

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

Standard Intent
The individuals who bear overall responsibility for the patient's care or for a particular phase of care should be identified in a manner that is made known to the personnel and patients.

Criteria

12.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

12.2.1.3 The individuals responsible for patient care are qualified.

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

12.2.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable variation.*

Standard Intent
Clinical practice guidelines provide a means for improving quality and assist practitioners in making clinical decisions.
Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged, e.g. hepatitis E in a non-endemic area. Guidelines are found in the literature under many names including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the clinical leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines should be reviewed on a regular basis to ensure their continued relevance.

Criteria

12.2.2.1 Evidence-based clinical practice guidelines, relevant to the patients and services of the hospital, are available to guide patient care processes.

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

12.2.2.3 Guidelines are reviewed on a regular basis and updated when necessary.

12.2.3 *Policies and procedures guide the care of high risk patients and the provision of high risk services.*

Standard Intent
Some patients are considered high risk because of their age, condition or the critical nature of their needs. Children are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened,

confused or semi-comatose patient may be unable to understand the care process. In addition, the care required by these patients may need to be provided efficiently and rapidly.
High risk procedures are those associated with a relatively high rate of patient safety incidents and which have potentially severe complications.

Examples of high risk patients and procedures include (where applicable):
a) The care of emergency patients
b) The handling, use and administration of blood and blood products
c) The care of patients who are comatose
d) The care of patients with communicable diseases
e) The care of immuno-suppressed patients
f) The care of patients on chemotherapy and radiotherapy
g) The care of patients on dialysis
h) The use of restraint and the care of patients in restraint
i) The care of frail and/or dependent patients of any age

Criteria

12.2.3.1 Documented protocols, clinical guidelines or standard operating procedures for identified high risk patients and procedures, which include items (a)-(i) in the standard intent above as a minimum, are available and readily accessible.

12.2.3.2 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

12.3 Assessment of Patients

12.3.1 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent
When a patient enters a ward, the specific information required and the procedures for obtaining and documenting this information depend on the patient's needs and on the setting in which care is being provided.
Documented hospital policy should define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations. These findings should be used throughout the care process to evaluate patient progress and understand the need for reassessment. It is essential that assessments are documented comprehensively and can be easily retrieved from the patient's record.
Hospital policy should define the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the hospital.

Criteria

12.3.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

12.3.1.4 Assessments are performed within appropriate time frames and are adequately documented in the patient's records according to hospital policy.

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

Standard Intent

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

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. When appropriate, the assessment process should be modified to respect local cultural practices. The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin. Planning for discharge should be commenced during this initial assessment process. When the medical assessment was conducted by a different healthcare organisation, a legible copy of the findings must be placed in the patient's record. Any significant changes in the patient's condition since this assessment must be recorded.

Criteria

12.3.2.1 Each patient admitted has an initial assessment according to hospital policy.

12.3.2.2 The initial assessment includes health history.

12.3.2.3 The initial assessment includes physical examination.

12.3.2.4 The initial assessment includes functional and nutritional examination, where applicable.

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

12.3.2.6 The initial assessment includes psychological assessment, where applicable.

12.3.2.7 The initial assessment includes cultural assessment, where applicable.

12.3.2.8 The initial assessment results in an initial diagnosis.

12.3.2.9 The patient's medical, nursing and other healthcare needs identified during the initial assessment are documented.

12.3.3 *Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.*

Standard Intent

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

Criteria

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

12.3.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care to inform the treatment plan, which includes the goals of care.

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

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

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

Standard Intent

The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy. Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.

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

Criteria

12.3.4.1 The patient's clinical records are completed according to hospital policy.

12.3.4.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

12.3.4.3 Information exchanged includes a summary of the care provided.

12.3.4.4 Information exchanged includes the patient's progress.

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

12.3.4.6

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

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

12.4 Patient Care

12.4.1 *The care provided to each patient is planned and documented in the patient's record.*

Standard Intent

A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional. The care plan should include the care to be delivered and the intended goals of care. Collaborative care and treatment team meetings or similar patient discussions must be recorded.
Diagnostic and other procedures must be ordered by individuals qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders. The reason for requesting diagnostic imaging or laboratory tests should be recorded if this reason will be required for interpretation of the results.

The hospital must decide:

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

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients and verbal orders, including those given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

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

12.4.1.2 The patient's response to care and therapeutic interventions is documented in the patient record.

12.4.1.3 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

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

12.4.1.5 Reassessments are performed at appropriate regular intervals and following a change in the patient's condition and documented in the patient's record.

12.4.1.6 Care plans are revised when necessary in response to the findings of reassessments.

12.4.2 *Each healthcare professional supports patient, family and caregiver participation in care decisions and care processes.*

Standard Intent

The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations.
Personnel involved in patient, family and caregiver education should collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective.
Education should be focused on the specific knowledge and skills that the patient, family members and caregivers will need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.
It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to remain an inpatient rather than receiving care as an outpatient.
Information relating to the planning and delivery of education should be recorded in a consistent location in the patient record and follow a standardised format.

Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

12.4.2.1 Patients and families indicate that they have received health education appropriate to their condition.

12.4.2.2 Patients and families indicate that they have been informed about the clinical management of their condition.

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

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

12.4.3 *Adequate information is provided when obtaining informed consent from patients or their legal representatives.*

Standard Intent

Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.

The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

a) Discussion of the patient's diagnosis and why the procedure is advised
b) The expected benefits of the procedure
c) The likelihood of success of the procedure
d) A thorough explanation of the proposed procedure
e) The potential risks and complications of the procedure
f) A discussion of viable alternative options including risks and benefits
g) The potential risks of refusing the proposed procedure
h) Confirmation that the patient or their legal representative has understood the information provided
i) An opportunity for the patient or their legal representative to ask questions
j) Comprehensive documentation of the process followed to obtain informed consent
k) How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g. learning difficulties) or by virtue of their physical illness (e.g. comatose)
l) Documentation of the signature of the patient or their legal representative for written consent
m) Documentation of verbal consent in the patient record
n) The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.

The leaders must agree and implement a process for the documentation of verbal consent.

Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient/parent/legal representative and the personnel member providing the information to confirm that the step has been completed satisfactorily.

Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements.

Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure. Where this is not the case, the patient/parent/legal representative should be informed of which healthcare professional will be performing the procedure.

Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. Where permissible according to Namibian legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

12.4.3.1 There is a documented process for obtaining or confirming informed consent.

12.4.3.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

12.4.3.3 Verbal consent is obtained and recorded according to hospital policy.

12.4.4 *Pre-and post-procedural assessments are documented.*

Standard Intent

Medical care may include invasive procedures related to the medical condition, such as arterial embolisation and other interventional radiological procedures, endoscopy, biopsy, etc. The management of these interventions is considered in this section of the standards.

The pre-anaesthetic medical assessment determines whether the patient's medical condition is stable enough to allow for surgical intervention or the planned procedure and may significantly influence the pre- and intraprocedural management of the patient. All information regarding the medical assessment, investigation, treatment and review of the patient must be available to the doctor performing the anaesthetic assessment.

A patient's post-procedural care at ward level is related to the procedure and the findings of the procedure. The report of the procedure must be available within an acceptable time frame to provide post-procedural care to the patient. Results of monitoring influence intra- and post-procedural decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

Criteria

12.4.4.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

12.4.4.2 Patients have a pre-procedural diagnosis recorded before anaesthesia.

12.4.4.3 A post-procedural diagnosis is documented.

12.4.4.4 The name of the medical practitioner responsible for the procedure is documented.

12.4.4.5 The patient’s physiological status is monitored during the post-procedural

12.4.5 *The hospital implements processes to support the patient in managing pain.*

Standard Intent

While pain may be part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain must be respected and supported.
To ensure that this right is implemented, the hospital should develop processes to:

- Identify patients with pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context oftheir personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

12.4.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

12.4.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

12.4.6 *The hospital develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully understand the reasons why specific decisions are taken. To accomplish this, all personnel must be made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:

a) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) Sensitively addressing issues such as autopsy and organ donation
c) Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care where appropriate
d) Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs

Criteria

12.4.6.1 Policies and procedures regarding end-of-life care, which include (a)-(d) in the standard intent above as a minimum, are implemented.

12.4.6.2 The patient, family and significant other(s) are involved in care decisions.

12.4.6.3 Pain and primary or secondary symptoms are managed according to hospital policy.

12.4.6.4 Religious and cultural needs of patients and their families or significant others are identified and met.

12.5 Medication Management

12.5.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards. Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian legal requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction. "Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary.

Doors, hinges and seals must all be functional.

Criteria

12.5.1.1 Medication is ordered according to hospital policy.

12.5.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

12.5.1.4 Medication identified for special control by legislation or hospital policy are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

12.5.1.5 Medication identified for special control by legislation or hospital policy are accurately accounted for.

12.5.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

12.5.1.7 Medication is stored in a clean environment.

12.5.1.8 A dedicated refrigerator is available for medication requiring storage at low temperatures.

12.5.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

12.5.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

12.5.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

12.5.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

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

Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.

The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters, etc. Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant.

The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed. In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

12.5.2.1 Policies and procedures that guide the safe prescribing and administration of medication are implemented.

12.5.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

12.5.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

12.5.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

12.5.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

12.5.2.6 There is evidence that patients are identified before medication is administered.

12.5.2.7 Medication is checked against the original prescriptions and administered as prescribed.

12.5.2.8 The medication prescribed for and administered to each patient is recorded.

12.5.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

12.5.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

12.5.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

12.6 Food and Nutrition Therapy

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

Standard Intent
A qualified caregiver should order appropriate food or other nutritional substitutes. The patient should participate in planning and selecting foods. The patient's family may participate in providing food when appropriate. If so, they must be educated as to which food is contraindicated in the patient's clinical condition and potential interactions between certain food and medication where relevant. When possible, patients should be offered a variety of food choices consistent with their nutritional status.
The nutritional status of the patients is monitored.

Criteria

12.6.1.1 Food appropriate to the patient is regularly available.

12.6.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

12.6.1.3 Wherever possible, patient food preferences are respected and substitutions made available.

12.6.1.4 When families provide food, they are educated about the patient’s dietary limitations.

12.6.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

12.6.1.7 Nutrition therapy provided, whether oral, enteral or parenteral, is written in the patient's record.

12.6.1.8 Response to nutrition therapy is monitored and recorded.

12.7 Continuity of Care

12.7.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent
As patients move through a healthcare organisation from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission are more likely to occur, exposing the patient to avoidable risks. The hospital should document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

12.7.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

12.7.1.2

12.7.1.3 Individuals responsible for the patient's care and its coordination are identified for all phases of patient care.

12.7.1.4 Continuity and coordination are evident throughout all phases of patient care.

12.7.1.5 When a patient is transferred within the hospital, they are accompanied by their patient record.

12.7.1.6 Patient handover between healthcare professionals is standardised according to hospital policy.

12.7.2 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent
Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare facility only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral facility) or while under the care of the outpatient department.
Hospital policy must clearly describe this referral process.

Criteria

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

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

12.7.2.3 Follow-up care based on the findings of investigations and/or consultations performed outside the referring hospital is documented in the patient record.

12.7.3 *There is a process to transfer patients to another organisation to meet their continuing needs.*

Standard Intent
This standard refers to the process by which a patient is discharged from the transferring hospital and handed over to receive ongoing care at another healthcare organisation.
Transfer may be to a higher level of care for specialised consultation and/or treatment, or for less intensive services such as sub-acute care or long-term rehabilitation.
To ensure continuity of care, adequate information must accompany the patient.
Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer. The process for transferring the patient must consider transportation needs as well as clinical needs.

Criteria

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

12.7.3.2 When a patient is transferred to another healthcare organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions performed by the transferring hospital.

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

12.7.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

12.7.4 *There is an organised process to discharge patients.*

Standard Intent
Care planning should include arrangements to meet the patients' continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing. The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability. At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting. The discharge summary must contain the following content as a minimum:

a) The diagnosis of main and significant illnesses
b) The results of investigations that will influence further management
c) All procedures performed
d) The patient's condition at discharge
e) Discharge medication
f) Follow-up arrangements where appropriate, including emergency review

Criteria

12.7.4.1 There is a documented process to discharge patients.

12.7.4.2 Where the initial assessment indicates that discharge planning will be required, planning requirements are included in the patient's care plan and completed as scheduled.

12.7.4.3 The hospital works with the family, caregivers, healthcare practitioners and agencies outside the hospital to ensure timely and appropriate discharge.

12.7.4.4 Patients and where appropriate their families or caregivers are given understandable follow-up instructions which are documented in the patient's record.

12.7.4.5 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

12.7.4.6 Each record contains a copy of the discharge summary.

12.8 Quality Improvement

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

Standard Intent

This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team ensures that standards are set throughout the hospital. Within each department or service, unit managers ensure that standards are set for the particular unit. Departmental or service managers should use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structures to ensure coordinated quality improvement activities throughout the hospital.
Quality monitoring is typically applied to high risk, high volume or high cost activities, or areas of concern identified by personnel, patients or visitors. Some examples of activities that may benefit from quality monitoring include:

a) Patient assessment
b) Procedures carried out
c) The use of antibiotics and other medication
d) Medication errors
e) The use of blood and blood products
f) Patient and family expectations and satisfaction

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

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

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

Criteria

12.8.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

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

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

12.8.1.4 A documentation audit system is in place.

12.9 Patient Rights

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

Standard Intent

This refers to the implementation of hospital policy on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

12.9.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

12.10 Prevention and Control of Infection

12.10.1 *The department/service implements infection prevention and control processes.*

Standard Intent

This refers to the implementation of hospital systems for infection prevention and control (Service Element 8).

Criteria

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

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

12.10.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

12.10.1.7 Infection control processes include safe injection practices, including single-use injection devices.

12.10.1.8 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

12.11 Risk Management

12.11.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

12.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

12.11.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

12.11.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

12.11.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

12.11.1.5 Fire safety measures are implemented.

12.11.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

13 Obstetric and Maternity Care

OVERVIEW OF OBSTETRIC AND MATERNITY CARE

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow-up. Activities specific to the obstetric/maternity care setting, whether for adult or neonatal patients, are provided in addition to the basic patient care and will be assessed on the relevant services provided by the specific unit or service.

These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel among others. Each member of the team has a clear role to play in the patient's package of care services which is determined by their particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team.
A care plan for each patient is based on an assessment of individual needs. The required care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medication, rehabilitative services or a combination of these. A care plan alone is not sufficient to achieve optimal outcomes unless delivery of the services is coordinated, integrated and monitored.

Continuity of care:
From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers.
Throughout all phases of care, patient needs must be matched with appropriate resources both within and, when necessary, outside the hospital.
Transfers to and from specialised units, such as critical care and operating theatre, must be in accordance with criteria that determine the appropriateness of such transfers.
Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively and implemented by the leaders of the various settings and services to ensure coordination of care

Standards

13.1 Facilities and Equipment

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

Standard Intent
In order to provide safe patient care, each service requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment is safely stored in a room or cupboard used for this purpose only. No cleaning equipment should be stored in areas where clean linen, medical supplies or food are stored. There must be adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation. Adequate lighting and ventilation must be provided. Nurse call systems must be available at bedsides and in bathrooms and toilets and connected to the emergency power supply.

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

Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes as a minimum:

a) An ECG monitor
b) A CPR board (if required)
c) Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
d) A bag-mask manual ventilator
e) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) An introducer/stylet for endotracheal intubation
g) A syringe to inflate the endotracheal tube cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (paediatric sizes)
k) Drugs for cardiac arrest, coma, seizures and states of shock (paediatric doses)
l) A defibrillator or automated external defibrillator (AED) with infant and paediatric paddles/pads within three minutes of any patient collapsing

Criteria

13.1.1.1 Patient and personnel accommodation and equipment in the service are adequate to meet patient care needs.

13.1.1.2 Oxygen and vacuum supplies meet patient care requirements.

13.1.1.3 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

13.1.1.4 There is evidence that equipment is maintained in accordance with hospital policy.

13.1.1.5 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

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

13.1.1.7 There are isolation rooms available which comply with the minimum requirements for isolation.

13.1.1.8 Electricity and water are available in accordance with the hospital's arrangements.

13.1.2 *There is a dedicated area for the preparation of infant feeds.*

Standard Intent

Professional guidelines for obstetric/maternity care services recommend the personnel and resources required to manage the service safely. The personnel in the ward should be in possession of these guidelines and ensure that the recommendations are implemented. These guidelines provide norms for staffing an obstetric/maternity care unit, and also for the services and facilities required.

Each delivery room must have at least:

- One cardio-tocograph machine
- An infant warming and resuscitation cart
- An incubator with adjustable temperature and separate oxygen supply
- A foetal monitor
- Equipment for inhalation analgesia
- There should be a temperature-controlled nursery which has:
- Suitable bassinettes
- Photo-therapy lights
- A panel for viewing babies

Criteria

13.1.2.1 Current guidelines for the provision of obstetric/maternity care services and facilities are followed.

13.1.2.2 Staffing of the service complies with accepted staffing norms for obstetric/maternity care services.

13.1.2.3 Available medical equipment complies with accepted norms for obstetric/maternity care services.

13.1.2.1 Where resuscitation, intensive care, life support or obstetric/maternity monitoring equipment is used that does not have built-in battery backup units, there is an uninterruptible power supply (UPS) that complies with relevant requirements and is regularly serviced and tested.

13.1.2.4 Security measures are adequate to safeguard newborns, including identification of newborns and restricted access and exit monitoring in wards.

13.1.3 *There is a dedicated area for the preparation of infant feeds.*

Standard Intent

Infant feeds should be prepared in a hygienically clean area with adequate provision for infection control measures. This dedicated area can be either a designated milk kitchen or a designated area in the ward kitchen. A sink with a double bowl and separate hand wash basin should be provided in either setting. A refrigerator for the exclusive use of milk feeds should be available with facilities provided for warming the feeds.

Criteria

9.4.4.1 Personnel working in the feed preparation area wear protective clothing such as gloves, masks and aprons.

9.4.4.2 Appropriate hand washing facilities are available in the feed preparation area with appropriate disinfectant solutions.

9.4.4.3 Appropriate facilities and equipment to clean and disinfect utensils in the feed preparation area are available and functional.

9.4.4.4 Information about disinfectant solutions and frequency of replacement in the feed preparation area is displayed.

9.4.4.5 There is clear signage of unauthorised entry on the door to limit people traffic.

9.4.4.6 The storage cupboard for baby formula is clearly marked and locked.

13.2 Service Management

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

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

Criteria

13.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

13.2.1.3 The individuals responsible for patient care are qualified.

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

13.2.1.5 The requirements of antenatal, labour and postnatal wards and nurseries are individually included in the staffing requirements.

13.2.1.6 A registered midwife and/or medical practitioner is present at every birth.

13.2.1.7 Healthcare professionals, specifically doctors and nurses, indicate that they have access to adequate supervision.

13.2.1.8 Specialists are available for consultation.

13.2.1.9 At least one person is available at all times who is qualified (medical practitioner or advanced midwife) in the management of maternal and neonatal emergencies.

13.2.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable variation.*

Standard Intent
Clinical practice guidelines provide a means for improving quality and assist practitioners and patients in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged, e.g. hepatitis E in a nonendemic area.
Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the clinical leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once implemented, guidelines are reviewed on a regular basis to ensure their continued relevance.

Criteria

13.2.2.1 Evidence based clinical practice guidelines, relevant to the patients and services of the hospital, are available to guide patient care processes.

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

13.2.2.3 Guidelines are reviewed on a regular basis and updated when necessary.

13.2.3 *Policies and procedures guide the care of high risk patients and the provision of high risk services.*

Standard Intent

Some patients are considered high risk because of their condition or the critical nature of their needs. The frightened, confused or semi-comatose patient may be unable to understand the care process or participate in decisions regarding their care. In addition, the care required by these patients may need to be provided efficiently and rapidly.

High risk procedures are those associated with a relatively high rate of patient safety incidents and which have potentially severe complications. Examples of high risk patients and procedures include (where applicable):

a) The care of emergency patients
b) The handling, use and administration of blood and blood products
c) The care of patients with communicable diseases
d) The care of immuno-suppressed patients
e) The use of restraint and the care of patients in restraint
f) The security of newborn babies

The clinical and managerial leaders take responsibility for:

- The identification of those patients and services considered as high risk
- The development of documented protocols or standard operating procedures in collaboration with all relevant personnel to ensure competent and consistent care
- Training of personnel in the implementation of these agreed documented protocols or standard operating procedures.

Clinical guidelines should be consulted in the formulation of these documents to ensure that the care provided in these situations is in accordance with current best practice in relation to the care offered to high risk patients, the clinical decision to perform high risk procedures and the method of performing these procedures.

Monitoring implementation of these guidelines provides the necessary information to ensure that the required standards of care are met for all relevant patients and services.

Criteria

13.2.3.1 Documented protocols, clinical guidelines or standard operating procedures for identified high-risk patients and procedures, which include items (a)-(f) in the standard intent above as a minimum, are available and readily accessible.

13.2.3.2 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

13.3 Assessment of Patients

13.3.1 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent

When a patient enters a ward, the specific information required and the procedures for obtaining and documenting this information depend on the patient's needs and on the setting in which care is being provided. Documented hospital policy must define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations.

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

Hospital policy must define the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings are verified on admission to the hospital.

Criteria

13.3.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

13.3.1.4 Assessments are performed within appropriate time frames and are comprehensively documented in the patient's records according to hospital policy.

13.3.2 *Each patient has an initial assessment that complies with current policies, procedures and guidelines*

Standard Intent

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

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, those in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. When appropriate, the assessment process should be modified to respect local cultural practices.

The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge should be commenced during this initial assessment process.

When the medical assessment was conducted by a different healthcare organisation, a legible copy of the findings should be filed in the patient's record. Any significant changes in the patient's condition since this assessment should be recorded.

Criteria

13.3.2.1 Each patient admitted has an initial assessment according to hospital policy.

13.3.2.2 The initial assessment includes health history.

13.3.2.3 The initial assessment includes physical examination.

13.3.2.4 The initial assessment includes functional and nutritional examination, where applicable.

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

13.3.2.6 The initial assessment includes psychological assessment, where applicable.

13.3.2.7 The initial assessment includes cultural assessment, where applicable.

13.3.2.8 The initial assessment includes antenatal history.

13.3.2.9 The initial assessment includes maternal and foetal examination.

13.3.2.10 The initial assessment results in an initial diagnosis.

13.3.2.11 The patient's medical, nursing and other healthcare needs identified during the initial assessment are documented.

13.3.1 Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.

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

Criteria

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

13.3.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care and used to develop the treatment plan, which includes the goals of care.

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

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

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

Standard Intent
The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy. Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team delivered care, multi-departmental patient care rounds, combined care planning

forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.
The patient, family and others should be included in the decision-making process when appropriate. The patient's record must contain a history of all care provided by the multidisciplinary team and be made available to all relevant caregivers who are authorised to access its content.

Criteria

13.3.4.1 The patient's clinical records are completed according to hospital policy.

13.3.4.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

13.3.4.3 Information exchanged includes a summary of the care provided.

13.3.4.4 Information exchanged includes the patient's progress.

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

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

13.3.4.7 The time of each patient record entry can be

13.4 Patient Care

13.4.1 *The care provided to each patient is planned and documented in the patient's record.*

Standard Intent

A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional. The care plan should include the care to be delivered and the intended goals of care.
Collaborative care and treatment team meetings or similar patient discussions must be recorded.
Diagnostic and other procedures must be ordered by individuals qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.
The reason for requesting diagnostic imaging or laboratory tests should be recorded if this reason will be required for interpretation of the results.
The hospital decides:

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

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients and verbal orders, including orders given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

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

13.4.1.2 The patient's response to care and therapeutic interventions is documented in the patient record.

13.4.1.3 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

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

13.4.1.5 The maternal and foetal conditions and the progress of labour are recorded on a partogram in every labour.

13.4.1.6 Reassessments are performed at appropriate regular intervals and following a change in the patient's condition and documented in the patient's record.

13.4.1.7 Care plans are revised when necessary in response to the findings of reassessments.

13.4.2 *Each healthcare professional supports patient, family and caregiver participation in care decisions and care processes*

Standard Intent

The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations. Personnel involved in patient, family and caregiver education must collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective.

Education must be focused on the specific knowledge and skills that the patient, family members and caregivers will need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.

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

Information relating to the planning and delivery of education must be recorded in a consistent location in the patient record and follow a standardised format.

Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

13.4.2.1 Patients and families indicate that they have received health education appropriate to their condition.

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

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

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

13.4.3 *Adequate information is provided when obtaining informed consent from patients or their legal representatives.*

Standard Intent

Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.

The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

- Discussion of the patient's diagnosis and why the procedure is advised
- The expected benefits of the procedure
- The likelihood of success of the procedure
- A thorough explanation of the proposed procedure
- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure
- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent
- How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g.delirium, learning difficulties, etc.) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.

The leaders must agree and implement a process for the documentation of verbal consent.

Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.

Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements.

Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure. Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. [4]
Where permissible according to country-specific legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

13.4.3.1 There is a documented process for obtaining or confirming informed consent.

13.4.3.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

13.4.3.3 Verbal consent is obtained and recorded according to hospital policy.

13.4.4 *Pre-and post-procedural assessments are documented.*

Standard Intent

The pre-anaesthetic medical assessment determines whether the patient's medical condition is stable enough to allow for surgical intervention or the planned procedure and may significantly influence the pre- and intraprocedural management of the patient. All information regarding the medical assessment, investigation, treatment and review of the patient must be available to the doctor performing the anaesthetic assessment.
In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition. A patient's post-procedural care at ward level is related to the procedure and the findings of the procedure. The report of the procedure must be available within an acceptable time frame to provide post-procedural care to the patient. Results of monitoring influence intra- and post-procedural decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

Criteria

13

13.4.3

13.4.4.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

13.4.4.2 Patients have a pre-procedural diagnosis recorded before anaesthesia.

13.4.4.3 A post-procedural diagnosis is documented.

13.4.4.4 The name of the medical practitioner responsible for the procedure is documented.

13.4.4.5 The patient's physiological status is monitored during the post-procedural period.

13.4.5 *The hospital implements processes to support the patient in managing pain.*

Standard Intent

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

To ensure that this right is implemented, the hospital should develop processes to:

- Identify patients with pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

13.4.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

13.4.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

13.4.6 *The hospital develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully understand the reasons why specific decisions are taken. To accomplish this, all personnel must be made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:

a) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) Sensitively addressing issues such as autopsy and organ donation
c) Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care where appropriate
d) Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs

Criteria

13.4.6.1 Policies and procedures regarding end-of-life care, which include (a)-(d) in the standard intent above as a minimum, are implemented.

13.4.6.2 The patient, family and significant other(s) are involved in care decisions.

13.4.6.3 Pain and primary or secondary symptoms are managed according to hospital policy.

13.4.6.4 Religious and cultural needs of patients and their families or significant others are identified and met.

13.5 Medication Management

13.5.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards. Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian legal requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction. "Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary. Doors, hinges and seals must all be functional.

Criteria

13.5.1.1 Medication is ordered according to hospital policy.

13.5.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

13.5.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

13.5.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

13.5.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

13.5.1.7 Medication is stored in a clean environment.

13.5.1.8 A dedicated refrigerator is available for medication requiring storage at low temperatures.

13.5.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

13.5.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

13.5.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

13.5.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

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

Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.

The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters, etc. Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant.

The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed. In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

13.5.2.1 Policies and procedures that guide the safe prescribing and administration of medication are implemented.

13.5.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

13.5.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

13.5.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

13.5.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

13.5.2.6 There is evidence that patients are identified before medication is administered.

13.5.2.7 Medication is checked against the original prescriptions and administered as prescribed.

13.5.2.8 The medication prescribed for and administered to each patient is recorded.

13.5.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

13.5.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

13.5.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

13.6 Food and Nutrition Therapy

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

Standard Intent
A qualified caregiver should order appropriate food or other nutritional substitutes. The patient should participate in planning and selecting foods. The patient's family may participate in providing food when appropriate. If so, they must be educated as to which foods are contraindicated in the patient's clinical condition and potential interactions between certain food and medication where relevant.
When possible, patients should be offered a variety of food choices consistent with their nutritional status. The nutritional status of the patients is monitored.

Criteria

13.6.1.1 Food appropriate to the patient is regularly available.

13.6.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

13.6.1.3 Wherever possible, patient food preferences are respected and substitutions made available.

13.6.1.4 When families provide food, they are educated about the patient's dietary limitations.

13.6.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

13.6.1.7 Nutrition therapy provided, whether oral, enteral or parenteral, is documented in the patient's record.

13.6.1.8 Response to nutrition therapy is monitored and recorded.

13.7 Continuity of Care

13.7.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Intent of 13.7.1
As patients move through a healthcare organisation from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission are more likely to occur, exposing the patient to avoidable risks. The hospital should document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

13.7.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

13.7.1.2 Individuals responsible for the patient's care and its coordination are identified for all phases of patient care.

13.7.1.3 Continuity and coordination are evident throughout all phases of patient care.

13.7.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

13.7.1.5 Patient handover between healthcare professionals is standardised according to hospital policy.

13.7.2 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent
Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare facility only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral facility) or while under the care of the outpatient department.
Hospital policy must clearly describe this referral process.

Criteria

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

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

13.7.2.3 Follow-up care based on the findings of investigations and/or consultations performed outside the referring hospital is documented in the patient record.

13.7.3 *There is a process to transfer patients to another organisation to meet their continuing needs.*

Standard Intent
This standard refers to the process by which a patient is discharged from the transferring hospital and handed over to receive ongoing care at another healthcare organisation, i.e. the facility receiving the transferred patient. Transfer may be to a higher level of care for specialised treatment, or for less intensive services such as admission to a primary care clinic to await delivery or receive postnatal care. To ensure continuity of care, adequate information must accompany the patient.

Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs as well as clinical needs. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer.

Criteria

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

13.7.3.2 When a patient is transferred to another healthcare organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions performed by the referring (transferring) hospital.

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

13.7.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

13.7.4 *There is an organised process to discharge patients.*

Standard Intent
Care planning should include arrangements to meet the patient's continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing.
The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability. At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting". The discharge summary must contain the following content as a minimum:

a) The diagnosis of main and significant illnesses
b) The results of investigations that will influence further management
c) All procedures performed
d) The patient's condition at discharge
e) Discharge medication
f) Follow-up arrangements where appropriate, including emergency review

Criteria
13.7.4.1 There is a documented process to discharge patients.

13.7.4.2 Where the initial assessment indicates that discharge planning will be required, planning requirements are included in the patient's care plan and completed as scheduled.

13.7.4.3 The hospital works with the family, caregivers, healthcare practitioners and agencies outside the hospital to ensure timely and appropriate discharge.

13.7.4.4 Patients and where appropriate their families or caregivers are given understandable follow-up instructions which are documented in the patient's record.

13.7.4.5 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

13.7.4.6 Each record contains a copy of the discharge summary.

13.8 Quality Improvement

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

Standard Intent

This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team is responsible for ensuring that standards are set throughout the hospital. Within each department or service, unit managers must ensure that standards are set for the particular unit. Departmental or service managers must use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structures to ensure coordinated quality improvement activities throughout the hospital.

Quality monitoring is typically applied to high risk, high volume or high cost activities, or areas of concern identified by personnel, patients or visitors.

Some examples of activities that may benefit from quality monitoring include:

a) Patient assessment
b) Mortality and morbidity rates
c) Surgical procedures carried out
d) The use of antibiotics and other medication
e) Medication errors
f) The use of blood and blood products
g) Patient and family expectations and satisfaction

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

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

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

Criteria

13.8.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

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

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

13.8.1.4 A documentation audit system is in place.

13.9 Patient Rights

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

Standard Intent

This refers to the implementation of hospital policy on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

13.9.1.3 The personnel respect the rights of patients and families to receive treatment and the right to refuse treatment.

13.10 Prevention and control of Infection

13.10.1 *The department/service implements infection prevention and control processes*

Standard Intent

This refers to the implementation of hospital systems for infection prevention and control (Service Element 8).

Criteria

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

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

13.10.1.2 Personnel are trained in correct hand washing procedures.

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

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

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

13.10.1.6 Infection control processes include safe injection practices, including single-use injection devices.

13.10.1.7 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

13.11 Risk Management

13.11.1 *The department/service implements risk management processes.*

Standard Intent

This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

13.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

13.11.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

13.11.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

13.11.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

13.11.1.5 Fire safety measures are implemented.

13.11.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

14 Operating Theatre and Anaesthetic Services

OVERVIEW OF OPERATING THEATRE AND ANAESTHETIC SERVICES

Services provided in the operating theatre and anaesthetic department are considered high risk services. To minimise these risks to both patients and personnel, effective collaboration between relevant services is essential. Relevant services refers to all services contributing to the delivery of care in the operating theatre, for example infection control, occupational health (including health and safety committees), pharmacy, medical equipment maintenance, supply chain management, etc., in addition to the doctors, nurses and theatre assistants.

Anaesthesia, sedation and surgical interventions are complex processes which are performed frequently in a hospital. They require complete and comprehensive patient assessment, integrated care planning, continuous patient monitoring and rigorously selected criteria for transfer out of the theatre suite.

The anaesthesia and surgery standards are applicable wherever anaesthesia, sedation, surgical and other invasive procedures requiring written informed consent are performed. This includes hospital operating theatres, day surgery or day hospital units, dental and other outpatient clinics, emergency services, intensive care units and any other setting where anaesthesia and surgery are required. The term "anaesthetist" in this service element refers to the healthcare professional responsible for administering anaesthesia. Anaesthesiologist refers to a medical professional (doctor) who has specialised in anaesthesiology.

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

The standards in this service element take into account comments from standards users and surveyors, research into developments in Operating Room procedures and the WHO Safe Surgery Guidelines.

Standards

14.1 Facilities and Equipment, Supplies and Medication

14.1.1 *Facilities for safe surgical and anaesthetic care are provided and maintained.*

Standard Intent

The design of the theatre suite should provide space for the reception, induction of anaesthesia, surgery, recovery and observation of patients. There must be areas for the disposal and collection of used equipment and waste, including contaminated waste and sharps. Safe and adequate storage space for pharmaceutical and surgical supplies must be available, including separate lockable cupboards for dangerous drugs and other scheduled medicines. Flammable substances must be stored in cupboards which are fire-resistant and contain
spills.

Theatre personnel should be provided with office facilities, a restroom, washrooms, toilets and changing facilities with separate space for their personal clothing and theatre clothing. Facilities should be equipped according to the requirement lists approved for use in the service. There must be scrubbing facilities in each theatre, with hot and cold running water and elbow-operated taps. There must be an anaesthetist's chair, an operating table with Trendelenburg position control, at least one lateral padded straight arm support and an infusion pole. Space and facilities should be available for setting up surgical trays and for autoclaving instruments.

Criteria

14.1.1.1 The design of the theatre suite provides space for the reception, induction of anaesthesia, surgery, recovery and observation of patients.

14.1.1.2 The theatre suite is equipped in accordance with approved requirement lists.

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

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

14.1.1.5 Access to the theatre suite is controlled.

14.1.1.6 There is access to sterilisation and disinfection facilities.

14.1.1.7 There is a system for controlling the environmental temperature and humidity that ensures safe limits for anaesthetised patients in accordance with professional society guidelines.

14.1.1.8 Where resuscitation, intensive care, life support or critical monitoring equipment without built-in battery backup units is used, there is an uninterruptible power supply (UPS), which is regularly serviced and tested.

14.1.1.9 There is either an UPS or a battery backup system for the theatre lamp, which is regularly tested, with such tests being fully documented.

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

14.1.1.11 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

14.1.2 *Anaesthetic equipment, supplies and medication comply with the recommendations of anaesthetic professional organisations or other authoritative sources.*

Standard

Anaesthetic risks are significantly reduced when appropriate, well-functioning equipment is used to administer anaesthesia and monitor patients, and adequate supplies of medication and medical supplies are available for routine and emergency services. Each hospital must understand the recommended equipment, supplies and medication required to provide anaesthetic services to its patient population. Recommendations regarding equipment, supplies and medication can come from a government agency, national or international anaesthetic professional organisations or other authoritative sources. An effective equipment maintenance programme must ensure that adequate equipment is available for the provision of safe anaesthesia.

Criteria

14.1.2.1 Anaesthetic mixture components are available and used in accordance with hospital policy.

14.1.2.2 The recommendations of anaesthetic professional organisations or other authoritative sources guide the provision and use of breathing circuits.

14.1.2.3 The recommendations of anaesthetic professional organisations or other authoritative sources guide the use of scavenging equipment for removing vapours and anaesthetic gases.

14.1.2.4 The recommendations of anaesthetic professional organisations or other authoritative sources guide the provision and use of monitoring equipment.

14.1.2.5 The recommendations of anaesthetic professional organisations or other authoritative sources guide the provision and use of ancillary equipment.

14.1.2.6 Medication is available according to the requirements of the level of care provided.

14.1.2.7 A medication trolley is available for the exclusive use of the anaesthetist in each theatre.

14.1.2.8 A tracheostomy tray is available.

14.1.3 *Medical equipment available meets the minimum requirements for the level of care provided.*

Criteria

14.1.3.1 Equipment and instrumentation for routine and emergency surgery must be available according to hospital policy for the level of care provided.

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

14.1.4 *Resuscitation and personal protective equipment are provided in the operating theatre.*

Standard

Theatre personnel must prepare for any emergencies through the provision of resuscitation equipment and personal protective equipment.

Criteria

14.1.4.1 Standardised resuscitation equipment is available in all relevant areas of the operating theatre suite.

14.1.4.2 Resuscitation equipment shows evidence of regular checking.

14.1.4.3 Resuscitation equipment and supplies have clearly defined instructions for use.

14.1.4.4 There is a mechanism for summoning assistance in an emergency.

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

14.1.4.6 Hazard or warning notices are displayed.

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

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

Criteria
14.1.5.1 The recovery area forms part of the theatre suite.

14.1.5.2 There are an adequate number of recovery beds for the patients from the operating theatre.

14.1.5.3 There is adequate lighting.

14.1.5.4 The provision, use and maintenance of recovery room equipment comply with the guidelines for practice of the relevant professional society.

14.2 Service Management

14.2.1 *The operating theatre and anaesthetic services are managed and staffed to provide a safe and effective service.*

Standard
The individuals who bear overall responsibility for the patient's care or for a particular phase of care must be identified in the patient's record or in a manner that is made known to the personnel. The theatre management team should work with the central management team to ensure adequate and appropriate management processes and an adequate staffing complement for the operating theatre, anaesthetic service and recovery room.

There may not be a formally constituted theatre users' committee, but the abovementioned functions must be performed at some level. For example, clinical forums may provide an opportunity for medical practitioners to meet with management.
The qualifications of those privileged to administer anaesthesia in the hospital must be documented in accordance with current professional society standards. Where privileges assigned to individuals are not formally documented, the hospital must implement processes to ensure that restrictions are imposed on who may administer anaesthesia.
The patient has the right not to be subjected to prolonged anaesthesia for the surgeon's convenience. This is of particular importance in settings where surgeons have tight schedules and may instruct anaesthetists to commence anaesthesia before they arrive in the operating theatre, in order to save time.
Anaesthesia may also be prolonged in large academic institutions in settings where the specialist surgeon moves between theatres to undertake only the more complicated procedures and leaves the rest of the procedure to other surgeons and students.

Criteria

14.2.1.1 A senior professional who is suitably qualified and experienced is in charge of the theatre and the recovery area.

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

14.2.1.3 There is a theatre users' committee or equivalent, which meets regularly and consists of representatives from all relevant services.

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

14.2.1.5 Anaesthesia is administered only by medical practitioners or other professionals who are privileged by the hospital to do so.

14.2.1.6 Trainee anaesthetists are under the supervision of trained anaesthesiologists.

14.2.1.7 The person administering anaesthesia is directly responsible for only one anaesthetised patient at a time.

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

14.2.1.9 The surgeon performing the procedure(s) is present in the operating theatre before the anaesthetist commences the administration of the anaesthetic.

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

14.2.1.11 Nursing personnel trained and/or experienced in recovery room care are available until the patient has fully recovered.

14.2.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable variation.*

Standard

Clinical practice guidelines assist practitioners in making clinical decisions in accordance with current best practice.

Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these represent the highest risk areas of care for patients and the hospital. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by hospital leaders and clinical practitioners before implementation.

This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines should be reviewed on a regular basis to ensure they remain up-to-date with the latest evidence. This standard deals with clinical guidelines for anaesthetic services. Guidelines in relation to surgical care will be assessed on the surgical ward(s).

Criteria

14.2.2.1 Evidence-based clinical practice guidelines, relevant to the patients and services of the hospital are available to guide patient care processes.

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

14.2.2.3 Guidelines are reviewed and adapted on a regular basis according to hospital policy.

14.2.3 *Documented policies and procedures relating to the activities in the operating theatre are implemented.*

Standard

Policies and procedures are necessary to guide the administration of the operating theatre and anaesthetic services to ensure the smooth operation of those services and to ensure that personnel act swiftly and in a coordinated manner in an emergency. These policies and procedures should be made available to all theatre, recovery room and anaesthetic personnel who should be aware of their content, and implementation of these policies and procedures should be monitored.

Biohazards which need to be monitored and notified include radiation, laser and electrical hazards. Policies and procedures must be available to ensure that informed consent is documented. Policies and procedures should specify the procedure to be followed to ensure that the patient is correctly identified, the nature of surgery and the site and side of the surgery are correctly documented and that these details have been confirmed with the patient prior to the administration of any sedative medication.

Processes during surgery, such as the use of instruments and counting procedures, must be documented to ensure coordination and safety.

Policies and procedures for the operating theatre should include the following:

a) Required qualifications of persons who administer anaesthesia and of persons who assist the anaesthetist
b) Pre-operative assessment and pre-medication
c) Implementation of the WHO Surgical Safety Checklist or equivalent checklist
d) Patient identification
e) Checking of consent documents or verification of consent
f) Preparation of patients for surgery
g) Verification of the nature and site of the operation
h) Verification of the last oral intake
i) Medication identified for special control (by Namibian law or hospital policy)
j) Patient positioning
k) Duties of the theatre and recovery room nurses
l) Specifying the instruments required for specific operations
m) Aseptic techniques
n) Recording of tissue(s) and specimen(s) collected
o) Intra-operative recording required
p) Counting procedures for swabs, instruments and needles and procedures to be followed in the event of incorrect counts
q) Assessing the fitness of patients to leave the recovery area
r) Scheduling of patients for elective and emergency surgical procedures
s) Theatre cleaning
t) Notification of biohazards

Criteria

14.2.3.1 Policies and procedures that guide the activities of the operating theatre services, which include items (a)-(t) in the standard intent above as a minimum, are implemented.

14.2.3.2 Policies and procedures relating to the anaesthetic service are implemented.

14.2.3.3 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

14.2.4 *Policies and procedures that guide the care of patients undergoing moderate and deep sedation are implemented.*

Standard

Sedation – in particular moderate and deep sedation – poses a risk to patients and thus should be provided using clear definitions, policies and procedures. The degrees of sedation occur on a continuum, and a patient may progress from one degree to another, based on the medication administered, route and dosages. Important considerations include the patient's ability to maintain protective reflexes and an independent, continuous patent airway; and to respond to physical stimulation or verbal commands. Sedation policies and procedures indicate:

a) How planning will occur, and will include the identification of differences between adult and paediatric populations, or other special considerations
b) Documentation required for the care team to work and communicate effectively
c) Special content considerations, if appropriate
d) Patient monitoring requirements
e) Special qualifications or skills of personnel involved in sedation processes
f) The availability and use of specialised equipment

Criteria

14.2.4.1 Policies and procedures regarding the care of patients undergoing moderate and deep sedation, which include (a)-(f) in the standard intent above as a minimum, are implemented.

14.2.4.2 There is a pre-sedation assessment, according to hospital policy, to evaluate risk and appropriateness of sedation for the patient.

14.2.4.3 A qualified individual monitors the patient during sedation and during the period of recovery from sedation and documents the monitoring.

14.2.4.4 Moderate and deep sedation are administered according to hospital policy.

14.3 Peri-Operative Care

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

Standard

The anaesthetist must monitor and record the physiological status of the patient during anaesthesia and enter the drugs, intravenous fluids and anaesthetic agents used in the patient's anaesthetic record. The anaesthetist must have access to the patient care notes, and review the findings of the medical examination. It is important that each health professional has access to the records of other care providers, in accordance with hospital policy.

All the criteria related to this standard will be assessed by undertaking an audit of randomly selected records of patients who have undergone surgical procedures. If copies of the intra-operative records are not available in the patient records, it must be established if they are kept elsewhere e.g. by the anaesthetists. Wherever the records are kept, documented evidence will be sought and the criteria marked according to findings.

Criteria

14.3.1.1 The patient's physiological status is continuously monitored during anaesthesia and surgery.

14.3.1.2 The results of such monitoring are entered into the patient's record.

14.3.1.3 The anaesthetic agents used are entered into the patient's anaesthetic record.

14.3.1.4 Analgesia administered on conclusion of the surgical procedure is documented in the patient's record.

14.3.2 *There is a system to monitor and document each patient's post-anaesthetic status and to discharge the patient from the recovery area according to accepted guidelines.*

Standard

Physiological monitoring provides reliable information about the patient's status during the administration of anaesthesia and the recovery period. Monitoring methods depend on the patient's pre-anaesthetic status, anaesthetic choice and the complexity of the surgical or other procedure performed during anaesthesia. In all cases, however, the monitoring process is continuous and the results are entered into the patient's record. Monitoring during anaesthesia provides the basis for monitoring during the post-anaesthetic recovery period. The ongoing, systematic collection and analysis of data on the patient's status in recovery support decisions about moving the patient to other settings and less intensive services. Only a suitably qualified and experienced registered nurse or a designated member of the medical personnel may carry out monitoring in the recovery area.
Recording of monitoring data provides the documentation to support discharge decisions.

Patients must be discharged from the post-anaesthesia recovery area in one of the following ways:

a) The patient is discharged by a fully qualified anaesthetist or other individual authorised by the individual(s)responsible for managing the anaesthetic service.
b) The patient is discharged by a nurse or similarly qualified individual in accordance with post-anaesthesia criteria developed by the hospital's leaders and the discharge is documented in the patient's record.
c) The patient is discharged to a unit which has been designated as appropriate for post-anaesthesia or post-sedation care of selected patients, such as an intensive care unit.
d) The time of arrival in and discharge from the recovery area must be recorded. Signatures of those who hand over and those who receive the patient must be recorded.

Criteria

14.3.2.1 The anaesthetist is responsible for supervising the recovery period.

14.3.2.2 The qualifications and experience of personnel members who may monitor patients are documented.

14.3.2.3 Monitoring is appropriate to the patient's condition during the post- anaesthetic recovery period.

14.3.2.4 Monitoring findings are documented in the patient's record.

14.3.2.5 The individual responsible for discharging the patient according to items (a) and (b) in the intent statement signs the discharge in the patient record.

14.3.2.6 Verbal orders are documented according to hospital policy.

14.3.2.7 Times of arrival in and discharge from the recovery area are recorded.

14.3.2.8 Established criteria are used to make decisions to discharge patients from the recovery room.

14.3.2.9 Patient safety is ensured by the correct implementation of the handover procedure from the recovery room personnel to the unit/ward personnel.

14.3.2.10 Signatures of those receiving the patient are recorded.

14.4 Quality Improvement

14.4.1 *A formalised proactive quality improvement approach is maintained in the theatre and anaesthetic services.*

Standard
This refers to the implementation of hospital quality improvement processes (Service Element 7). It is the responsibility of the management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality management structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.
Some examples of activities that may benefit from quality monitoring include:

- Surgical site infection
- Unplanned return to the operating theatre
- Surgical deaths
- Case length
- Length of the operating day
- The number of times blood was not available
- Significant discrepancy between pre-and post-operative diagnosis.

The following will be evaluated:

- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems - Identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of patient care, but to the environment within

which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

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

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

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

14.4.1.4 The operating department team participates in the hospital's surveillance of surgical capacity, volume and results.

14.4.1.5 A documentation audit system is in place.

14.5 Patient Rights

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

Standard

This refers to the implementation of hospital policies on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

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

14.6 Prevention and Control of Infection

14.6.1 *The department/service implements infection prevention and control processes.*

Standard

This refers to the implementation of hospital processes on infection prevention and control (Service Element 8).

Criteria

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

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

14.6.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

14.6.1.7 Infection control measures of particle counts and bacterial growth are performed in each theatre according to hospital policy.

14.6.1.8 Infection control processes include safe injection practices, including single use injection devices.

14.6.1.9 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

14.7 Risk Management

14.7.1 *The department/service implements risk management processes.*

Standard
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

14.7.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

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

14.7.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

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

14.7.1.5 Fire safety measures are implemented.

14.7.1.6 The hospital's policy on handling, storing and disposing of healthcare waste is implemented.

15 Critical Care

OVERVIEW OF CRITICAL CARE

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow-up. These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel, among others. Each provider has a clear role to play in the patient's package of care services which is determined by each team member's particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team.

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

Continuity of care:

From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers. Throughout all phases of care, patient needs should be matched with appropriate resources within and, when necessary, outside the hospital.

Transfers to and from specialised units, such as critical care and the operating theatre, must be in accordance with criteria that determine the appropriateness of such transfers. Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively and implemented by all staff and monitored by the leaders of the various settings and services to ensure coordination of care.

Standards

15.1 Facilities and Equipment

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

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment must be safely stored in a room or cupboard used for this purpose only. No cleaning equipment should be stored in areas where clean linen, medical supplies or food are stored. There must be adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation.

Adequate lighting and ventilation should be provided.

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

Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes as a minimum:

a) An ECG monitor

b) A CPR board (if required)
c) Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
d) d) A bag-mask manual ventilator
e) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) An introducer /stylet for endotracheal intubation
g) A syringe to inflate the ETT cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
k) Drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)

A defibrillator or automated external defibrillator (AED with adult paddles/pads (and infant paddles/pads where applicable) within three minutes of any patient collapsing.

Criteria

15.1.1.1 Patient and personnel accommodation and equipment in the service are adequate to meet patient care needs.

15.1.1.2 Oxygen and vacuum supplies meet patient care requirements.

15.1.1.3 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

15.1.1.4 There is evidence that equipment is maintained in accordance with hospital policy.

15.1.1.5 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

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

15.1.1.7 There are isolation rooms available which comply with the minimum requirements for isolation.

15.1.1.8 Electricity and water are available in accordance with the hospital's arrangements.

15.1.2 *Specific resources are available for the provision of safe care to patients in the critical care unit.*

Standard Intent

Professional guidelines for critical care services recommend the personnel and resources required to manage the service safely. The personnel in the ward must be in possession of these guidelines and ensure that the recommendations are implemented. These guidelines provide norms for staffing a critical care unit, and also for the services and facilities required.

Where there is a neonatal ICU, there should be a temperature-controlled nursery which has:

- Suitable bassinettes
- Photo-therapy lights
- A panel for viewing babies
- A designated area for preparing infant feeds

- Facilities allocated for washing utensils used when preparing infant feeds

Criteria

15.1.2.1 Current guidelines for the provision of critical care services and facilities are followed.

15.1.2.2 Available medical equipment complies with accepted norms for critical care services.

15.1.2.3 Where resuscitation, intensive care, life support or critical monitoring equipment is used that does not have built-in battery backup units, there is an uninterruptible power supply (UPS) that complies with relevant requirements and is regularly serviced and tested.

15.1.3 *There is a dedicated area for the preparation of infant feeds*

Standard Intent

This standard applies only to neonatal ICU. Where no neonatal ICU services are provided, this standard will be scored not applicable.

Infant feeds should be prepared in a hygienically clean area with adequate provision for infection control measures. This dedicated area can be either a designated milk kitchen or a designated area in the ward kitchen. A sink with a double bowl and separate hand wash basin should be provided in either setting. A refrigerator for the exclusive use of milk feeds should be available with facilities provided for warming the feeds.

Criteria

15.1.3.1 Personnel working in the feed preparation area wear protective clothing such as gloves, masks and aprons.

15.1.3.2 Appropriate hand washing facilities are available in the feed preparation area with appropriate disinfectant solutions.

15.1.3.3 Appropriate facilities and equipment to clean and disinfect utensils in the feed preparation area are available and functional.

15.1.3.4 Information about disinfectant solutions and frequency of replacement in the feed preparation area is displayed.

15.1.3.5 There is clear signage of unauthorised entry on the door to limit people traffic.

15.1.3.6 The storage cupboard for baby formula is clearly marked and locked.

15.2 Service Management

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

Standard Intent

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

Criteria

15.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

15.2.1.2 Staffing of the service complies with accepted staffing norms for critical care services.

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

15.2.1.4 The individuals responsible for patient care are qualified.

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

15.2.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable variation.*

Standard Intent

Clinical practice guidelines provide a means for improving quality and assist practitioners and patients in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged, e.g. hepatitis E in a nonendemic area.

Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the clinical leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines are reviewed on a regular basis to ensure their continued relevance.

Criteria

15.2.2.1 Evidence-based clinical practice guidelines, relevant to the patients and services of the hospital, are available to guide patient care processes.

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

15.2.2.3 Guidelines are reviewed on a regular basis and updated when necessary.

15.2.3 *Policies and procedures guide the care of high risk patients and the provision of high risk services*

Standard Intent

Some patients are considered high risk because of their age, condition or the critical nature of their needs. Children and the frail or infirm elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or semi-comatose patient may be unable to understand the care process. In addition, the care required by these patients may need to be provided efficiently and rapidly. High risk procedures are those associated with a relatively high rate of patient safety incidents and which have potentially severe complications.

Examples of high risk patients and procedures include (where applicable):

a) The care of emergency patients
b) The handling, use and administration of blood and blood products
c) The care of patients who are comatose
d) The care of patients with communicable diseases
e) The care of immuno-suppressed patients
f) The care of patients on chemotherapy and radiotherapy
g) The care of patients on dialysis
h) The use of restraint and the care of patients in restraint
i) The care of frail, dependent patients of any age

The clinical and managerial leaders should take responsibility for:

- The identification of those patients and services considered as high risk
- The development of documented protocols or standard operating procedures in collaboration with all relevant personnel to ensure competent and consistent care

Clinical guidelines should be consulted in the formulation of these documents to ensure that the care provided in these situations is in accordance with current best practice in relation to the care offered to high risk patients, the clinical decision to perform high risk procedures and the method of performing these procedures. Monitoring implementation of these guidelines provides the necessary information to ensure that the required standards of care are met for all relevant patients and services.

Criteria

15.2.3.1 Documented protocols, clinical guidelines or standard operating procedures for identified high risk patients and procedures, which include items (a)-(i) in the standard intent above as a minimum, are available and readily accessible.

15.2.3.2 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

15.2.4 *Admission or transfer to units providing critical care services is determined by established criteria.*

Standard Intent

Units or services that provide intensive care (for example a post-surgical intensive care unit) or that provide specialised services (for example the care of patients with burns, or organ transplant units), are costly and usually have limited space and personnel. Each hospital must establish criteria for identifying those patients who require the level of care provided in such units. Appropriate individuals from the intensive or specialised services should participate in developing these criteria. The criteria should be used to determine direct entry to the unit, for example directly from the emergency service. The criteria should be also used to authorise transfer into the unit from within or outside the hospital, and in deciding when a patient no longer requires the services of the unit and can be transferred to another level of care.

Criteria

15.2.4.1 The hospital has established entry and/or transfer criteria for its intensive and specialised units, to meet special patient needs.

15.2.4.2 The criteria are physiological where possible and appropriate.

15.2.4.3 Appropriate individuals are involved in developing the criteria.

15.2.4.4 Personnel are trained to apply the criteria.

15.2.4.5 Patients transferred or admitted to intensive and specialised units/services meet the criteria, as documented in the patient's record.

15.2.4.6 Patients who no longer meet the criteria to remain in the unit are transferred or discharged.

15.3 Assessment of Patients

15.3.1 *All patients cared for by the hospital have their health care needs identified through an established assessment process.*

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

Documented hospital policy must define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations. These findings should be used throughout the care process to evaluate patient progress and understand the need for reassessment. It is essential that assessments are documented well and can be easily retrieved from the patient's record.

Hospital policy must define the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings are verified on admission to the hospital.

Criteria

15.3.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

15.3.1.4 Assessments are performed within appropriate time frames and are comprehensively documented in the patient's records according to hospital policy.

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

Standard Intent
The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable assistance in these areas of assessment and in understanding the patient's wishes and preferences. Financial factors must be assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.
A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims

of abuse and neglect. When appropriate, the assessment process should be modified to respect local cultural practices.
The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin.
When the medical assessment was conducted by a different healthcare organisation, a legible copy of the findings must be placed in the patient's record. Any significant changes in the patient's condition since this assessment must be recorded.

Criteria

15.3.2.1 Each patient admitted has an initial assessment according to hospital policy.

15.3.2.2 The initial assessment includes health history.

15.3.2.3 The initial assessment includes physical examination.

15.3.2.4 The initial assessment includes functional and nutritional examination, where applicable.

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

15.3.2.6 The initial assessment includes psychological assessment, where applicable.

15.3.2.7 The initial assessment includes cultural assessment, where applicable.

15.3.2.8 The initial assessment results in an initial diagnosis.

15.3.2.9 The patient's medical, nursing and other healthcare needs identified during the initial assessment are documented.

15.3.3 *Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.*

Standard Intent

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

Criteria

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

15.3.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care and used to develop the treatment plan, which includes the goals of care.

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

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

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

Standard Intent
The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy. Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.
The patient, family and others should be included in the decision-making process when appropriate. The patient's record must contain a history of all care provided by the multidisciplinary team and be made available to all relevant caregivers who are authorised to access its content.

Criteria

15.3.4.1 The patient's clinical records are completed according to hospital policy.

15.3.4.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

15.3.4.3 Information exchanged includes a summary of the care provided.

15.3.4.4 Information exchanged includes the patient's progress.

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

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

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

15.4 Patient Care

15.4.1 *The care provided to each patient is planned and documented in the patient's record.*

Standard Intent
A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional. The care plan should include the care to be delivered and the intended goals of care.
Collaborative care and treatment team meetings or similar patient discussions must be recorded.
Diagnostic and other procedures must be ordered by individuals qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders. The reason for requesting diagnostic imaging or laboratory tests should be recorded if this reason will be required for interpretation of the results of these orders.

The hospital must decide:

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

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients or visitors and verbal orders, including those given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

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

15.4.1.2 The patient's response to care and therapeutic interventions is documented in the patient's record.

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

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

15.4.1.5 Reassessments are performed at appropriate regular intervals and following a change in the patient's condition and documented in the patient's record.

15.4.1.6 Care plans are revised when necessary in response to the findings of reassessments.

15.4.2 *Each health care professional supports patient, family and care giver participation in care decisions and care processes.*

Standard Intent

The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations. Personnel involved in patient, family and caregiver education must collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective.

Education must be focused on the specific knowledge and skills that the patient, family members and caregivers will need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment. It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to remain an inpatient rather than receiving care as an outpatient.

Information relating to the planning and delivery of education must be recorded in a consistent location in the patient record and follow a standardised format.

Community organisations that support health promotion and disease prevention education should be identified and when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

15.4.2.1 Patients and families indicate that they have received health education appropriate to their condition.

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

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

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

15.4.3 *Adequate information is provided when obtaining informed consent from patients or their legal representatives.*

Standard Intent
Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.
The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

- Discussion of the patient's diagnosis and why the procedure is advised
- The expected benefits of the procedure
- The likelihood of success of the procedure
- A thorough explanation of the proposed procedure
- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure
- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent
- How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g.delirium, learning difficulties, etc.) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.
The leaders must agree and implement a process for the documentation of verbal consent.
Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.
Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements.
Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure. Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. [4]
Where permissible according to country-specific legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

15.4.3.1 There is a documented process for obtaining or confirming informed consent.

15.4.3.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

15.4.3.3 Verbal consent is obtained and recorded according to hospital policy.

15.4.4 *Pre-and post-procedural assessments are documented.*

Standard Intent
Medical care may include invasive procedures related to the medical condition, e.g. cardiac catheterisation and other interventional radiological procedures, endoscopy, biopsy, etc. The management of these interventions is considered in this section of the standards.
The pre-anaesthetic medical assessment determines whether the patient's medical condition is stable enough to allow for surgical intervention or the planned procedure and may significantly influence the pre- and intra-procedural management of the patient. All information regarding the medical assessment, investigation, treatment and review of the patient must be available to the doctor performing the anaesthetic assessment.
A patient's post-procedural care at ward level is related to the procedure itself and the findings of the procedure. The report of the procedure must be available within an acceptable time frame to provide appropriate ongoing care on the ward following the procedure. Results of monitoring influence intra and post-procedural decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

Criteria

15.4.4.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

15.4.4.2 Patients have a pre-procedural diagnosis recorded before anaesthesia.

15.4.4.3 A post-procedural diagnosis is documented.

15.4.4.4 The name of the medical practitioner responsible for the procedure is documented.

15.4.4.5 The patient's physiological status is monitored during the post-procedural period.

15.4.5 *The hospital implements processes to support the patient in managing pain*

Standard Intent
While pain may be part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain must be respected and supported.
To ensure that this right is implemented, the hospital should develop processes to:

- Identify patients with pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context of theirpersonal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

15.4.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

15.4.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

15.4.6 *The hospital develops processes to manage end-of-life care.*

Standard Intent

Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully understand the reasons why specific decisions are taken. To accomplish this, all personnel must be made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:

a) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) Sensitively addressing issues such as autopsy and organ donation
c) Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care, where appropriate
d) Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs

Criteria

15.4.6.1 Policies and procedures regarding end-of-life care, which include (a)-(d) in the standard intent above as a minimum, are implemented.

15.4.6.2 The patient, family and significant other(s) are involved in care decisions.

15.4.6.3 Pain and primary or secondary symptoms are managed according to hospital policy.

15.4.6.4 Religious and cultural needs of patients and their families or significant others are identified and met.

15.5 Medication Management

15.5.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards. Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction. "Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.
Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary. Doors, hinges and seals must all be functional.

Criteria

15.5.1.1 Medication is ordered according to hospital policy.

15.5.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical Acts and Regulations and manufacturer guidelines (e.g. security, temperature control).

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

15.5.1.4 Medications identified for special control by legislation or hospital policy are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

15.5.1.5 Medications identified for special control by legislation or hospital policy are accurately accounted for.

15.5.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

15.5.1.7 Medication is stored in a clean environment.

15.5.1.8 A dedicated refrigerator is available for those medication requiring storage at low temperatures.

15.5.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

15.5.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

15.5.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

15.5.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

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

Each hospital must identify those individuals permitted to prescribe medication. These individuals have the requisite knowledge and experience and are permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.
The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters,etc.
Only personnel who are suitably trained and experienced are permitted to administer medication to patients and this responsibility must be documented.
The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and to identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses, and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant.
The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed.

In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be helpful in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

15.5.2.1 Policies and procedures that guide the safe prescribing and administration of medication are implemented.

15.5.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

15.5.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

15.5.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

15.5.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

15.5.2.6 There is evidence that patients are identified before medication is administered.

15.5.2.7 Medication is checked against the original prescriptions and administered as prescribed.

15.5.2.8 The medication prescribed for and administered to each patient is recorded.

15.5.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

15.5.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

15.5.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

15.6 Food and Nutrition Therapy

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

Standard Intent
A qualified caregiver orders appropriate food or other nutritional substitutes. The patient should participate in planning and selecting food. The patient's family may participate in providing food when appropriate. If so, they must be educated as to which foods are contraindicated in the patient's clinical condition and potential interactions between certain foods and medication where relevant.

When possible, patients should be offered a variety of food choices consistent with their nutritional status.
The nutritional status of the patients should be monitored.

Criteria

15.6.1.1 Food appropriate to the patient is regularly available.

15.6.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

15.6.1.3 Wherever possible, patient food preferences are respected and substitutions made available.

15.6.1.4 When families provide food, they are educated about the patient's dietary limitations.

15.6.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

15.6.1.7 Nutrition therapy provided, whether oral, enteral or parenteral, is documented in the patient's record.

15.6.1.8 Response to nutrition therapy is monitored and recorded.

15.7 Continuity of Care

15.7.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent

As patients move through a hospital from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission are more likely to occur, exposing the patient to avoidable risks. The hospital should therefore document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

15.7.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

15.7.1.2 Individuals responsible for the patient's care and its coordination are identified for all phases of patient care.

15.7.1.3 Continuity and coordination are evident throughout all phases of patient care.

15.7.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

15.7.1.5 Patient handover between healthcare professionals is standardised according to hospital policy.

15.7.2 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent

Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare organisation only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral facility) or while under the care of the outpatient department. Hospital policy must clearly describe this referral process.

Criteria

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

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

15.7.2.3 Follow-up care based on the findings of investigations and/or consultations performed outside the referring hospital is documented in the patient record.

15.7.3 *There is a process to transfer patients to another healthcare organisation to meet their continuing needs.*

Standard Intent

This standard refers to the process by which a patient is discharged from the transferring hospital and handed over to receive ongoing care at another healthcare organisation, i.e. the facility receiving the transferred patient. Transfer may be to a higher level of care for specialised treatment, or for less intensive services such as sub-acute care or long-term rehabilitation. To ensure continuity of care, adequate information must accompany the patient.

Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs as well as clinical needs. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer.

Criteria

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

15.7.3.2 When a patient is transferred to another healthcare organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions performed by the referring (transferring) hospital.

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

15.7.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

15.7.4 *There is an organised process to discharge patients.*

Standard Intent

Care planning should include arrangements to meet the patient's continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing. The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The discharge summary must contain the following content as a minimum:

a) The diagnosis of main and significant illnesses
b) The results of investigations that will influence further management
c) All procedures performed
d) The patient's condition at discharge
e) Discharge medication
f) Follow-up arrangements where appropriate, including emergency review

Criteria

15.7.4.1 There is a documented process to discharge patients.

15.7.4.2 The hospital works with the family, caregivers, healthcare practitioners and agencies outside the hospital to ensure timely and appropriate discharge.

15.7.4.3 Patients and where appropriate their families or caregivers are given understandable follow-up instructions which are documented in the patient's record.

15.7.4.4 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

15.7.4.5 Each record contains a copy of the discharge summary.

15.8 Quality Improvement

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

Standard Intent

This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team ensures that standards are set throughout the hospital. Within each department or service, unit managers ensure that standards are set for the particular unit. Departmental or service managers use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structures to ensure coordinated quality improvement activities throughout the hospital.

Quality monitoring is typically applied to high risk, high volume or high cost activities, or areas of concern identified by personnel, patients or visitors. Some examples of activities that may benefit from quality monitoring include:

- Patient assessment
- Procedures carried out
- The use of antibiotics and other medication
- Medication errors
- The use of blood and blood products

Patient and family expectations and satisfaction - Monitoring turnaround times for investigations requested.

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

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

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

Criteria

15.8.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

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

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

15.8.1.4 A documentation audit system is in place.

15.9 Patient Rights

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

Standard Intent
This refers to the implementation of hospital policy on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

15.9.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

15.10 Prevention and Control of Infection

15.10.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital systems for infection prevention and control (Service Element 8).

Criteria

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

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

15.10.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

15.10.1.7 Infection control processes include safe injection practices, including single-use injection devices.

15.10.1.8 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

15.11 Risk Management

15.11.1 *The department/service implements risk management processes.*

Standard Intent

This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

15.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

15.11.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

15.11.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

15.11.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

15.11.1.5 Fire safety measures are implemented.

15.11.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

15.11.1.7 Documented protocols, clinical guidelines or standard operating procedures for identified high risk patients and procedures, which include items (a)-(i) in the standard intent above as a minimum, are available and readily accessible.

15.11.1.8 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

15.12 Assessment of Patients

15.12.1 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent

When a patient enters a ward, the specific information required and the procedures for obtaining and documenting this information depend on the patient's needs and on the setting in which care is being provided. Documented hospital policy must define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations. These findings should be used throughout the care process to evaluate patient progress and understand the need for reassessment. It is essential that assessments are documented well and can be easily retrieved from the patient's record.

Hospital policy must define the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings should be verified on admission to the hospital.

Criteria

15.12.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

15.12.1.4 Assessments are performed within appropriate time frames and are adequately documented in the patient's records according to hospital policy.

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

Intent of 15.12.2

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

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. When appropriate, the assessment process should be modified to respect local cultural practices.

The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge should be commenced during this initial assessment process.

When the medical assessment was conducted by a different healthcare organisation, a legible copy of the findings should be placed in the patient's record. Any significant changes in the patient's condition since this assessment should be recorded.

Criteria

15.12.2.1 Each patient admitted has an initial assessment according to hospital policy.

15.12.2.2 The initial assessment includes health history.

15.12.2.3 The initial assessment includes physical examination.

15.12.2.4 The initial assessment includes functional and nutritional examination, where applicable.

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

15.12.2.6 The initial assessment includes psychological assessment, where applicable.

15.12.2.7 The initial assessment includes cultural assessment, where applicable.

15.12.2.8 The initial assessment results in an initial diagnosis.

15.12.2.9 The patient's medical, nursing and other healthcare needs identified during the initial assessment are documented.

15.12.3 *Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.*

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

Criteria

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

15.12.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care to inform the treatment plan, which includes the goals of care.

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

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

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

Standard Intent
The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy. Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.

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

Criteria

15.12.4.1 The patient's clinical records are completed according to hospital policy.

15.12.4.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

15.12.4.3 Information exchanged includes a summary of the care provided.

15.12.4.4 Information exchanged includes the patient's progress.

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

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

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

15.13 Patient Care

15.13.1 *The care provided to each patient is planned and documented in the patient's record.*

Standard Intent
A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional. The care plan should include the care to be delivered and the intended goals of care.
Collaborative care and treatment team meetings or similar patient discussions should be recorded.
Diagnostic and other procedures must be ordered by individuals qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.
The reason for requesting diagnostic imaging or laboratory tests should be recorded if this reason will be required for interpretation of the results.

The hospital must decide:

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

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients or visitors and verbal orders, including those given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

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

15.13.1.2 The patient's response to care and therapeutic interventions is documented in the patient record.

15.13.1.3 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

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

15.13.1.5 Reassessments are performed at appropriate, regular intervals and following a change in the patient's condition and documented in the patient's record.

15.13.1.6 Care plans are revised when necessary in response to the findings of re-assessments.

15.13.2 *Each healthcare professional supports patient, family and caregiver participation in care decisions and care processes.*

Standard Intent
The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking in account factors such as educational literacy, cultural beliefs and personal limitations.
Personnel involved in patient, family and caregiver education must collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective. Education must be focused on the specific knowledge and skills that the patient, family members and caregivers will

need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.
It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to remain an inpatient rather than receiving care as an outpatient. Information relating to the planning and delivery of education must be recorded in a consistent location in the patient record and follow a standardised format.
Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

15.13.2.1 Patients and families indicate that they have received health education appropriate to their condition.

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

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

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

15.13.3 *Adequate information is provided when obtaining informed consent from patients or their legal representatives.*

Standard Intent
Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.
The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

n) Discussion of the patient's diagnosis and why the procedure is advised
o) The expected benefits of the procedure
p) The likelihood of success of the procedure
q) A thorough explanation of the proposed procedure
r) The potential risks and complications of the procedure
s) A discussion of viable alternative options including risks and benefits
t) The potential risks of refusing the proposed procedure
u) Confirmation that the patient or their legal representative has understood the information provided
v) An opportunity for the patient or their legal representative to ask questions
w) Comprehensive documentation of the process followed to obtain informed consent
x) How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity, (e.g. delirium, learning difficulties, etc.) or by virtue of their physical illness, (e.g. comatose)
y) Documentation of the signature of the patient or their legal representative for written consent
z) Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.

The leaders must agree and implement a process for the documentation of verbal consent.
Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.

Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements. Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure. Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure.

Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. Where permissible according to Namibian legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

15.13.3.1 There is a documented process for obtaining or confirming informed consent.

15.13.3.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

15.13.3.3 Verbal consent is obtained and recorded according to hospital policy.

15.13.4 *Pre-and post-operative assessments are documented.*

Standard Intent
The pre-anaesthetic medical assessment determines whether the patient's medical condition is stable enough to allow for surgical intervention or the planned procedure and may significantly influence the pre- and intra-procedural management of the patient. All information regarding the medical assessment, investigation, treatment and review of the patient must be available to the doctor performing the pre-anaesthetic medical assessment. In an emergency, the initial medical assessment may be limited to the patient's apparent needs and condition.

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

A patient's post-procedural care at ward level is related to the procedure and the findings of the procedure. The report of the procedure must be available within an acceptable time frame to provide post-procedural care to the patient.

Results of monitoring influence intra- and post-procedural decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge. The term "procedure" refers to both minor and major surgical interventions.

Criteria

15.13.4.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

15.13.4.2 Patients have a pre-procedural diagnosis recorded before anaesthesia.

15.13.4.3 A post-procedural diagnosis is documented.

15.13.4.4 The name of the medical practitioner responsible for the procedure is documented.

15.13.4.5 The patient's physiological status is monitored during the post-procedural period.

15.13.5 *The hospital implements processes to support the patient in managing pain.*

Intent of 11.4.5
While pain may be part of the patient experience, unrelieved pain has adverse physical and psychological effects. The patient's right to appropriate assessment and management of pain must be respected and supported.

To ensure that this right is implemented, the hospital should develop processes to:

- Identify patients with pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

15.13.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

15.13.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

15.13.6 *The hospital develops processes to manage end-of-life care.*

Standard Intent
Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity guides all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully understand the reasons why specific decisions are taken.
To accomplish this, all personnel must be made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:

e) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
f) Sensitively addressing issues such as autopsy and organ donation

g) Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care where appropriate
h) Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs

Criteria

15.13.6.1 Policies and procedures regarding end-of-life care, which include (a)-(d) in the standard intent above

15.13.6.2 The patient, family and significant other(s) are involved in care decisions.

15.13.6.3 Pain and primary or secondary symptoms are managed according to hospital policy.

15.13.6.4 Religious and cultural needs of patients and their families or significant other(s) are identified and met.

15.14 Medication Management

15.14.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Intent of 11.5.1

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards. Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian legal requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction. "Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary. Doors, hinges and seals must all be functional.

Criteria

15.14.1.1 Medication is ordered according to hospital policy.

15.14.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

15.14.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

15.14.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

15.14.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

15.14.1.7 Medication is stored in a clean environment.

15.14.1.8 A dedicated refrigerator is available for those medication requiring storage at low temperatures.

15.14.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

15.14.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

15.14.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

15.14.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel should participate in a collaborative process to develop and monitor policies and procedures. Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.

The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheter, etc. Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant.
The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed.

In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

15.14.2.1 Policies and procedures that guide the safe prescribing and administration of medication are implemented.

15.14.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

15.14.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

15.14.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

15.14.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

15.14.2.6 There is evidence that patients are identified before medication is administered.

15.14.2.7 Medication is checked against the original prescriptions and administered as prescribed.

15.14.2.8 The medication prescribed for and administered to each patient are recorded.

15.14.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

15.14.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

15.14.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

15.15 Food and Nutrition Therapy

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

Standard Intent

A qualified caregiver should order appropriate food or other nutritional substitutes. The patient should participate in planning and selecting food. The patient's family may participate in providing food when appropriate. If so, they must be educated as to which food is contraindicated in the patient's clinical condition and potential interactions between certain food and medication where relevant.
When possible, patients should be offered a variety of food choices consistent with their nutritional status. The nutritional status of the patients is monitored.

Criteria

15.15.1.1 Food appropriate to the patient is regularly available.

15.15.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

15.15.1.3 Wherever possible, patient food preferences are respected and substitutions made available.

15.15.1.4 When families provide food, they are educated about the patient's dietary limitations.

15.15.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

15.15.1.7 Nutrition therapy provided, whether oral, enteral or parenteral, is written in the patient's record.

15.15.1.8 Response to nutrition therapy is monitored and recorded.

15.16 Continuity of Care

15.16.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent
As patients move through a healthcare organisation from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission are more likely to occur, exposing the patient to avoidable risks. The hospital should therefore document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

15.16.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

15.16.1.2 Individuals responsible for the patient’s care and its coordination are identified for all phases of patient care.

15.16.1.3 Continuity and coordination are evident throughout all phases of patient care.

15.16.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

15.16.1.5 Patient handover between healthcare professionals is standardised according to hospital policy.

15.16.2 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent
Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare facility only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral facility) or while under the care of the outpatient department.
hospital policy must clearly describe this referral process.

Criteria

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

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

15.16.2.3 Follow-up care based on the findings of investigations and/or consultations performed outside the referring hospital is documented in the patient record.

15.16.3 *There is a process to transfer patients to another organisation to meet their continuing needs.*

Standard Intent
This standard refers to the process by which a patient is discharged from the transferring hospital and handed over to receive ongoing care at another healthcare organisation, i.e. the facility receiving the transferred patient. Transfer may be to a higher level of care for specialised treatment, or for less intensive services such as subacute care or long-term rehabilitation. To ensure continuity of care, adequate information must accompany the patient.
Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs as well as clinical needs. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer.

Criteria

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

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

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

15.16.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

15.16.4 *There is an organised process to discharge patients.*

Standard Intent
Care planning should include arrangements to meet the patients' continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing. The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.
At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The discharge summary must contain the following content as a minimum:
g) The diagnosis of main and significant illnesses
h) The results of investigations that will influence further management
i) All procedures performed
j) The patient's condition at discharge
k) Discharge medication
l) Follow-up arrangements where appropriate, including emergency review

Criteria

15.16.4.1 There is a documented process to discharge patients.

15.16.4.2 Where the initial assessment indicates that discharge planning will be required, planning requirements are included in the patient's care plan and completed as scheduled.

15.16.4.3 The hospital works with the family, caregivers, healthcare practitioners and agencies outside the hospital to ensure timely and appropriate discharge.

15.16.4.4 Patients and where appropriate their families or caregivers are given understandable follow-up instructions which are documented in the patient's record.

15.16.4.5 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

15.16.4.6 Each record contains a copy of the discharge summary.

15.17 Quality Improvement

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

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team is responsible for ensuring that standards are set throughout the hospital. Within each department or service, unit managers must ensure that standards are set for the particular unit. Departmental or service managers must use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structures to ensure coordinated quality improvement activities throughout the hospital.

Quality monitoring is typically applied to high risk, high volume or high cost activities, or areas of concern identified by personnel, patients or visitors.

Some examples of activities that may benefit from quality monitoring include:

- Patient assessment
- Procedures carried out
- The use of antibiotics and other medication
- Medication errors
- The use of blood and blood products
- Patient and family expectations and satisfaction. The following will be evaluated:
- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, e.g. monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

15.17.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

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

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

15.17.1.4 A documentation audit system is in place.

15.18 Patient Rights

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

Standard Intent
This refers to the implementation of hospital policy on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

15.18.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

15.19 Prevention and Control of Infection

15.19.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital systems for infection prevention and control (Service Element 8).

Criteria

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

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

15.19.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

15.19.1.7 Infection control processes include safe injection practices, including single-use injection devices.

15.19.1.8 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

15.20 Risk Management

15.20.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

15.20.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

15.20.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

15.20.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

15.20.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

15.20.1.5 Fire safety measures are implemented.

15.20.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

16 Mental Health Service

OVERVIEW OF MENTAL HEALTH SERVICE

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow up.

These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel, among others. Each provider has a clear role to play in the patient's package of care services, which is determined by each team member's particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team.

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

Continuity of care:

From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers.

Throughout all phases of care, patient needs should be matched with appropriate resources within and, when necessary, outside the hospital.

Transfers to and from specialised units, must be in accordance with criteria that determine the appropriateness of such transfers.

Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively, implemented by all clinical personnel and monitored by the leaders of the various settings and services to ensure coordination of care.

16.1 Facilities and Equipment

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

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment must be safely stored in a room or cupboard used for this purpose only. No cleaning equipment should be stored in areas where clean linen, medical supplies or food are stored. There must be adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation.

Adequate lighting and ventilation should be provided.

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

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

Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes as a minimum:

a) An ECG monitor
b) A CPR board (if required)
c) Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
d) A bag-mask manual ventilator
e) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) An introducer /stylet for endotracheal intubation
g) A syringe to inflate the ETT cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
k) Drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
l) A defibrillator or automated external defibrillator (AED with adult paddles/pads (and infant paddles/pads where applicable) within three minutes of any patient collapsing.

Criteria

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

16.1.1.2 The initial assessment includes psychiatric assessment.

16.1.1.3 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

16.1.1.4 There is evidence that equipment is maintained in accordance with hospital policy.

16.1.1.5 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

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

16.1.1.7 Electricity and water are available in accordance with the hospital's arrangements.

16.2 Service Management

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

Standard Intent

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

Criteria

16.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

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

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

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

Standard Intent
Clinical practice guidelines provide a means to improve quality and assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by hospital leaders and clinical practitioners before implementation. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions. In particular in a mental health unit, guidelines should be followed as part of the decision-making process for prescribing treatment such as ECT and clozapine. This will ensure that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines should be reviewed on a regular basis to ensure their continued relevance.

Criteria

16.2.2.1 Evidence-based clinical practice guidelines relevant to the patients and services of the hospital are available to guide patient care processes.

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

16.2.2.3 Guidelines are reviewed on a regular basis and updated when necessary.

16.2.3 *Policies and procedures guide the care of high risk patients and the provision of high risk services.*

Standard Intent
Some patients are considered high risk because of their age, condition or the critical nature of their needs. Mental health patients, children and the frail or infirm elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened and/or confused patient may be unable to understand the care process when interventions to ensure the safety of the patient or those around them must be provided efficiently and rapidly.

The clinical and managerial leaders should take responsibility for identifying the patients and services considered high risk, using a collaborative process to develop policies and procedures and training personnel in their implementation.
It is particularly important that the policies or procedures indicate:

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

High risk procedures are those associated with a relatively high rate of patient safety incidents and which have potentially severe complications.

Examples of high risk patients and procedures include (where applicable):

a) The care of emergency patients
b) The care of patients with communicable diseases
c) The care of immuno-suppressed patients
d) The use of restraint and the care of patients in restraint
e) The care of frail, dependent patients
f) The care of young, dependent children
g) The use of seclusion and the care of patients in seclusion
h) The management of patients with eating disorders
i) The management of the detoxification stage of treatment
j) The management of patients who may be a danger to themselves or others
k) The administration of electro-convulsive therapy (ECT)including a mechanism to track the duration of seizure and care of patients following ECT
l) The management of the violent patient
m) The searching of patients, visitors, parcels and personnel for weapons and/or drugs.

The clinical and managerial leaders should take responsibility for:

- The identification of those patients and services considered as high risk
- The development of documented protocols or standard operating procedures to treat high risk patients or carryout high risk procedures, which should be developed in collaboration with all relevant personnel to ensure competent and consistent care
- Training of personnel in the implementation of these agreed documented protocols or standard operating procedures

Clinical guidelines should be consulted in the formulation of these documents to ensure that the care provided in these situations is in accordance with current best practice, including the clinical decision to perform high risk procedures and the method for performing these procedures.
Implementation of these documented protocols and standard operating procedures should be monitored to ensure that the required standards of care are met for all relevant patients and services.

Criteria

16.2.3.1 Policies and procedures for identified high risk patients and procedures, which include at least items (a)-(m) in the standard intent above, are implemented.

16.2.3.2 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

16.2.4 *Admission or transfer to the mental health unit is determined by established criteria.*

Standard Intent

Units or services that provide mental health services are costly and usually have limited space and personnel. The hospital should establish criteria for identifying those patients who require the level of care provided in such units. Appropriate individuals from the Mental Health Services must participate in developing these criteria. The criteria should be used to determine direct entry to the unit, for example directly from the emergency service.

The criteria should also be used to authorise transfer into the unit from within or outside the hospital, and in deciding when a patient no longer requires the services of the unit and can be transferred to another level of care.

Criteria

16.2.4.1 The unit has established entry and/or transfer criteria for its services, to meet special patient needs.

16.2.4.2 Appropriate individuals are involved in developing the criteria.

16.2.4.3 Personnel are trained to apply the criteria.

16.2.4.4 Patients transferred or admitted to the unit meet the criteria, as documented in the patient's record.

16.3 Assessment of Patients

16.3.1 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent
When a patient enters a ward, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided. The hospital should define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations.

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

The hospital should determine the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings should be verified on admission to the hospital.

Criteria

16.3.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

16.3.1.4 Assessments are performed within appropriate time frames and comprehensively documented in the patient's records according to hospital policy.

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

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

A functional and nutritional assessment will allow for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those in pain, patients suspected of drug and/or alcohol dependency and victims of abuse and neglect. The assessment process should be modified in accordance with local custom.

A psychosocial assessment of the child or adolescent receiving in-patient, residential, partial-hospitalisation, continuing out-patient, home care or case-management services and his or her family should include an evaluation of the effect of the family or guardian on the condition of the individual undergoing treatment and the effect of the condition on the family or guardian. As part of the assessment process, the hospital must identify the adult(s) who has/have legal custody, e.g. in the case of divorced parents. This may prevent conflicts during care or discharge planning that can be detrimental to the child or adolescent.

In terms of the care of intellectually disabled persons, family involvement must be encouraged. For many individuals, participation by family members will be a significant factor in achieving goals. The importance of family participation in treatment planning is related to age or disability factors, which determine the patient's level of dependence on their family for basic care.

The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

Planning for discharge should be commenced during the initial assessment process and involve the patient and their family or carers. When involvement of families or carers is appropriate in the development of treatment plans, patient consent must be obtained before these individuals are included in the planning process. Where treatment after discharge will involve community services, these services should be included in the multidisciplinary care planning process.

When the medical/psychological assessment was conducted outside the hospital, a legible copy of the findings should be filed in the patient's record. Any significant changes in the patient's condition since this assessment should be recorded.

Occasionally, patients are admitted to mental health services against their will due to legal intervention. These admissions are usually subject to national legislation. A copy of such legislation should be available in the unit and the assessment and admission of these patients must comply with legislative requirements.

Criteria

16.3.2.1 Each patient admitted has an initial assessment that meets hospital policy.

16.3.2.2 The initial assessment includes psychiatric assessment.

16.3.2.3 The initial assessment includes health history.

16.3.2.4 The initial assessment includes physical examination.

16.3.2.5 The initial assessment includes functional and nutritional examination, where applicable.

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

16.3.2.7 The initial assessment includes cultural assessment, where applicable.

16.3.2.8 The initial assessment results in an initial diagnosis.

16.3.2.9 The initial assessment results in the identification of the patient’s medical, nursing or other therapeutic needs.

16.3.2.10 Discharge planning is commenced with the initial assessment and involves the patient and their family or carers.

16.3.2.11 Where appropriate, treatment planning is done in collaboration with the patient's family and/or carers.

16.3.2.12 Patients admitted to the unit against their will are assessed, admitted and cared for in accordance with legislative requirements.

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

Standard Intent

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

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

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

Criteria

16.3.3.1 The patient's clinical records are completed according to hospital policy.

16.3.3.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

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

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

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

16.3.3.6 Patient care plans are formulated collaboratively by all healthcare professionals involved in the patient's care.

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

16.3.3.8 The team conducts periodic re-evaluation of each patient's plan of care to determine whether established goals are being or have been met and whether change in the patient’s condition requires modification of goals.

16.3.3.9 The team includes the patient and his/her family in the development and review of the plan of care, as appropriate.

16.3.3.10 A designated individual is responsible for the coordination and integration of care for each patient.

16.3.3.11 The multidisciplinary team meets regularly to coordinate patient care.

16.3.3.12 The care provided by the multidisciplinary team is documented according to hospital policy.

16.4 Patient Care

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

Standard Intent
A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional.
Collaborative care and treatment team meetings or similar patient discussions should be recorded.
Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.
The hospital must decide:

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

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients or visitors and verbal orders, including those given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

16.4.1.1 The planned care is provided and documented in the patient's record.

16.4.1.2 The patient's response to care and therapeutic interventions is documented in the patient record.

16.4.1.3 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

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

16.4.1.5 Reassessments are performed at appropriate, regular intervals and following a change in the patient's condition, and documented in the patient's record.

16.4.2 *Each patient participates in a structured treatment plan.*

Standard Intent
Each patient should have psychotherapeutic interviews with an appropriately qualified person to meet his/her needs. There should be a structured therapeutic environment which allows for group therapy, occupational therapy and music or art therapy, as required by individual patients.

Criteria

16.4.2.1 There is evidence of regular psychotherapeutic interviews as indicated by the programme and individual patient needs.

16.4.2.2 There is a range of therapeutic activities available, according to the identified needs of the patient.

16.4.2.3 There is documented participation of the patient with his or her family or significant other(s) in group therapy, as appropriate.

16.4.2.4 The patient has the least restrictive environment possible, with any restrictions placed upon him/her written into the treatment plan.

16.4.3 *Each healthcare professional supports patient, family and caregiver participation in care decisions and care processes.*

Standard Intent
The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations. Personnel involved in patient, family and caregiver education should collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective.

Education should be focused on the specific knowledge and skills that the patient, family members and caregivers require to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment. It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to remain an inpatient rather than receiving care as an outpatient.

Information relating to the planning and delivery of education should be recorded in a consistent location in the patient record and follow a standardised format. Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

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

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

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

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

16.4.4 *Adequate information is provided when obtaining informed consent from patients or their legal representatives*

Standard Intent
Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.
The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

- Discussion of the patient's diagnosis and why the procedure is advised
- The expected benefits of the procedure
- The likelihood of success of the procedure

- A thorough explanation of the proposed procedure
- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure
- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent
- How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g. delirium, learning difficulties, etc.) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.
The leaders must agree and implement a process for the documentation of verbal consent.
Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.
Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements.
Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure. Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure.
Where permissible according to country-specific legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

16.4.4.1 There is a documented process for obtaining or confirming informed consent.

16.4.4.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

16.4.4.3 Verbal consent is obtained and recorded according to hospital policy.

16.4.5 *Pre-and post-anaesthetic assessments are documented.*

Standard Intent

This standard applies to settings where electro-convulsive therapy (ECT) is administered. The pre-anaesthetic assessment determines if the patient is a medically fit to undergo the planned anaesthesia. The clinical assessment and results of investigations must be available to the medical practitioner performing the ECT. Post-ECT monitoring must be appropriate to the patient's condition.

Criteria

16.4.5.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

16.4.5.2 The results of diagnostic tests performed on the patient are recorded prior to the administration of anaesthesia.

16.4.5.3 The names of the anaesthetist, the medical practitioner who performs the ECT and other personnel, as required by law, are documented.

16.4.5.4 The patient's physiological status is monitored during the immediate post-ECT period.

16.4.6 *The hospital implements processes to support the patient in managing pain.*

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

- Identify patients with pain during initial assessment and reassessment
- Communicate with and provide education for, patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in pain assessment and management

Criteria

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

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

16.4.6.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

16.4.6.5 The hospital has processes to educate health professionals in assessing and managing pain.

16.4.7 *The hospital develops processes to manage end-of-life care.*

Standard Intent
Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully understand the reasons why specific decisions are taken.
To accomplish this, all personnel should be made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:

a) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) Sensitively addressing issues such as autopsy and organ donation
c) Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care, where appropriate

d) Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs
e) Referral to acute ward or healthcare organisation if the unit does not offer end-of-life care

Criteria

16.4.7.1 Policies and procedures regarding end-of-life care, which include (a)-(e) in the standard intent above as a minimum, are implemented.

16.4.7.2 The patient, family and significant other(s) are involved in care decisions.

16.4.7.3 Pain and primary or secondary symptoms are managed according to hospital policy.

16.4.7.4 Religious and cultural needs of patients and their families or significant others are identified and met.

16.5 Medication Management

16.5.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards. Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction.

"Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor.

Mostly these are steel cabinets, but solid wooden cupboards are also acceptable.

There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that the medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary. Doors, hinges and seals must all be functional.

Criteria

16.5.1.1 Medication is ordered according to hospital policy.

16.5.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

16.5.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

16.5.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

16.5.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

16.5.1.7 Medication is stored in a clean environment.

16.5.1.8 A dedicated refrigerator is available for medication requiring storage at low temperatures.

16.5.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

16.5.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

16.5.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

16.5.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

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

Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.

Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and to identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses, and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant.

The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed. In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors

through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

16.5.2.1 Policies and procedures that guide the safe prescribing, dispensing and administration of medication are implemented.

16.5.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

16.5.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

16.5.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

16.5.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

16.5.2.6 There is evidence that patients are identified before medication is administered.

16.5.2.7 Medication is checked against the original prescriptions and administered as prescribed.

16.5.2.8 The medication prescribed for and administered to each patient is recorded.

16.5.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

16.5.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

16.5.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

16.6 Food and Nutrition Therapy

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

Standard Intent
A qualified caregiver should order appropriate food or other nutritional substitutes. The patient should participate in planning and selecting foods. The patient's family may participate in providing food when appropriate. When they do, they should be educated as to which foods are contraindicated in the patient's clinical condition and potential interactions between certain foods and medication where relevant.

When possible, patients should be offered a variety of food choices consistent with their nutritional status. The nutritional status of the patients must be monitored.

Criteria

16.6.1.1 Food appropriate to the patient is regularly available.

16.6.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

16.6.1.3 Wherever possible, patient food preferences are respected and substitutions made available.

16.6.1.4 When families provide food, they are educated about the patient's dietary limitations.

16.6.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

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

16.6.1.8 Response to nutrition therapy is monitored and recorded.

16.7 Continuity of Care

16.7.1 *The hospital designs and carries out processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent
As patients move through a hospital from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks. The hospital should therefore document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

16.7.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

16.7.1.2 Individuals responsible for the patient's care and its coordination are identified for all phases of patient care.

16.7.1.3 Continuity and coordination are evident throughout all phases of patient care.

16.7.1.4 The record of the patient accompanies the patient when transferred within the hospital.

16.7.1.5 Patient handover between healthcare professionals is standardised according to hospital policy.

16.7.1.6 Documentation regarding the transfer of a patient from the forensic service to another service within the hospital meets legal requirements.

16.7.2 *There is a process known to personnel to refer patients for specialised consultation/investigations at other healthcare facilities.*

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

Criteria

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

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

16.7.2.3 Follow-up care based on the findings of investigations/consultations performed outside the hospital is documented in the patient record.

16.7.3 *There is a process to transfer patients to another healthcare organisation to meet their continuing needs.*

Standard Intent
Transfer may be for specialised consultation and/or treatment at another healthcare organisation, urgent services or for less intensive services such as sub-acute care or long-term rehabilitation. To ensure continuity of care, adequate information must accompany the patient.
Transfer may be an uncomplicated process or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs. The qualifications of the individual accompanying the patient must be appropriate.

Criteria

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

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

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

16.7.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

16.7.4 *There is an organised process to discharge patients.*

Standard
Care planning should include arrangements to meet the patient's continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing. The discharge summary is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability. At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The summary must contain at least:

a) The reason for admission
b) The diagnosis of main and significant illnesses
c) The results of investigations that will influence further management
d) All procedures performed
e) The patient's condition at discharge
f) Discharge medication
g) Follow-up arrangements where appropriate, including emergency review

Criteria

16.7.4.1 There is a documented process to discharge patients.

16.7.4.2 Where the initial assessment indicates that discharge planning will be required, planning requirements are included in the patient's care plan and completed as scheduled.

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

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

16.7.4.5 A discharge summary, which includes at least items (a)-(g) in the intent statement, is written by the medical practitioner at discharge of each patient.

16.7.4.6 Each record contains a copy of the discharge summary.

16.8 Special Psychiatric Services

16.8.1 *Where electro-convulsive therapy is provided, the service is managed and staffed to ensure patient safety.*

Standard Intent

Electro-convulsive therapy (ECT) is considered a high risk intervention. Collaboration between personnel in the therapy unit, health and safety representatives and those responsible for the supply and maintenance of equipment is essential.

ECT personnel must work with hospital leaders to ensure adequate and suitable management processes and staffing of the unit. The qualifications of those persons who administer anaesthesia in the ECT unit must be documented in accordance with current professional society standards.

An emergency trolley must be available in the ECT unit. The resuscitation equipment available must include at least:

- A defibrillator with adult paddles / pad
- An ECG monitor
- A CPR board (if required)
- Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
- A bag-mask manual ventilator
- A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
- An introducer /stylet for endotracheal intubation
- A syringe to inflate the ETT cuff
- Oropharyngeal tubes
- Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
- Appropriate facilities for intravenous therapy and drug administration
- Drugs for cardiac arrest, coma, seizures and states of shock

Criteria

16.8.1.1 A senior medical practitioner who is suitably qualified and experienced is in charge of the ECT service.

16.8.1.2 The design of the ECT treatment area provides space for the reception, anaesthetic induction, treatment, recovery and observation of patients.

16.8.1.3 Policies and procedures relating to the activities in the ECT unit are implemented.

16.8.1.4 There is documented evidence that the patient has consented to the procedure.

16.8.1.5 Anaesthesia is administered only by qualified anaesthesiologists.

16.8.1.6 Emergency resuscitation equipment is available in the ECT unit according to hospital policy.

16.8.1.7 Resuscitation equipment and trolley contents are checked prior to each administration of ECT.

16.8.1.8 There is a mechanism for summoning assistance in the event of an emergency.

16.8.2 *Where observation and/or forensic services are provided, they comply with Namibian legislation.*

Standard Intent
Non-clinical constraints affect admission, treatment and discharge decisions in hospitals providing forensic services. Such a hospital must often accept court-ordered admissions and therefore has limited ability to select the type of individuals it will serve. In addition, such hospitals often cannot limit their admissions to individuals requiring the level of care and services they offer. That is, such hospitals can be required by the courts and the forensic system to admit a significant number of individuals who may not require mental health services or who could be adequately served on an outpatient or partial-hospitalisation basis if security were not a concern. Furthermore, such a hospital often cannot give individuals increasing freedom (for example community visits) as part of their treatment programme or discharge them without a court order.

Criteria

16.8.2.1 Policies and procedures that guide the care and/or observation of forensic patients and the provision of forensic services are implemented.

16.8.2.2 Security or correctional personnel are educated/trained regarding their responsibilities in relation to assisting with the management of patients.

16.8.2.3 All seclusion or restraint, whether for clinical or non-clinical purposes, is documented in the patient's record.

16.8.2.4 There are mechanisms designed to facilitate communication and resolve conflict between judicial, correctional, penal, clinical and administrative agencies and those involved in an individual's care.

16.9 Quality Improvement

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

Standard Intent
This refers to the implementation of hospital processes on quality improvement (Service Element 7). It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central/coordinating structures for quality management. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

- Patient assessment
- The use of medication and medication errors
- The use of sedation and/or anaesthesia
- Patient and family expectations and satisfaction

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved.
- Graphed and/or tabled results, as appropriate.

A once-off project, for example, the supply of specific equipment, will be scored NC. Quality improvement processes, not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

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

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

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

16.9.1.4 A documentation audit system is in place.

16.10 Patient Rights

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

Standard Intent

This refers to the implementation of hospital policies on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews

Criteria

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

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

16.10.1.3 Personnel respect the rights of patients and families to treatment and to refuse treatment.

16.11 Prevention and Control of Infection

16.11.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes on infection prevention and control (Service Element 8).

Criteria

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

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

16.11.1.3 Personnel are trained in correct hand washing procedures.

16.11.1.4 Infection control processes include safe injection practices, including single-use injection devices.

16.11.1.5 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

16.12 Risk Management

16.12.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital processes on risk management (Service Element 5).

Criteria

16.12.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

16.12.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

16.12.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

16.12.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

16.12.1.5 Fire safety measures are implemented.

16.12.1.6 Hospital policy on handling, storing and disposing of healthcare waste is implemented.

17 Medical Oncology

OVERVIEW OF MEDICAL ONCOLOGY

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination.

Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow-up. These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel, among others. Each member of the team has a clear role to play in the patient's package of care services which is determined by their particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team. A care plan for each patient should be based on an assessment of individual needs. The required care may be preventive, palliative, curative or rehabilitative and may include the use of anaesthesia, surgery, medication, rehabilitative services or a combination of these. A care plan alone is not sufficient to achieve optimal outcomes unless delivery of the services is coordinated, integrated and monitored.

Continuity of care:
From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers. Throughout all phases of care, patient needs must be matched with appropriate resources both within and, when necessary, outside the hospital. Transfers to and from specialised units, such as critical care and the operating theatre, must be in accordance with criteria that determine the appropriateness of such transfers. Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively, implemented by all clinical personnel and monitored by the leaders of the various settings and services to ensure coordination of care.

Standards

17.1 Facilities and Equipment

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

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment must be safely stored in a room or cupboard used for this purpose only. No cleaning equipment should be stored in areas where clean linen, medical supplies or food are stored. There must be adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation. Adequate lighting and ventilation should be provided. Nurse call systems must be available at bedsides and in bathrooms and toilets and connected to the emergency power supply.

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

Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes as a minimum:

a) An ECG monitor
b) A CPR board (if required)
c) Suction apparatus (electrical or alternative) plus a range of soft and hard suction catheters
d) A bag-mask manual ventilator
e) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) An introducer /stylet for endotracheal intubation
g) A syringe to inflate the ETT cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
k) Drugs for cardiac arrest, coma, seizures and states of shock (including paediatric doses where applicable)
l) A defibrillator or automated external defibrillator (AED with adult paddles/pads (and infant paddles/pads where applicable) within three minutes of any patient collapsing.

Criteria

17.1.1.1 Patient and personnel accommodation and equipment in the service are adequate to meet patient care needs.

17.1.1.2 Oxygen and vacuum supplies meet patient care requirements.

17.1.1.3 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

17.1.1.4 There is evidence that equipment is maintained in accordance with hospital policy.

17.1.1.5 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

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

17.1.1.7 There are isolation rooms available which comply with the minimum requirements for isolation.

17.1.1.8 Electricity and water are available in accordance with the hospital's arrangements.

17.2 Service Management

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

Standard Intent

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

Criteria

17.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

17.2.1.3 The individuals responsible for patient care are qualified.

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

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

Standard Intent

Clinical practice guidelines provide a means for improving quality and assist practitioners and patients in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions, as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged.

Guidelines are found in the literature under many names including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by clinical leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once implemented, guidelines must be reviewed on a regular basis to ensure their continued relevance.

Criteria

17.2.2.1 Evidence-based clinical practice guidelines, relevant to the patients and services of the hospital, are available to guide patient care processes.

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

17.2.2.3 Guidelines are reviewed on a regular basis and updated when necessary.

17.2.3 *Policies and procedures guide the care of high risk patients and the provision of high risk services.*

Standard Intent

Some patients are considered high risk because of their age, condition or the critical nature of their needs. Children and the elderly are commonly in this group as they may not be able to speak for themselves, understand the care process or participate in decisions regarding their care. Similarly, the frightened, confused or comatose patient is unable to understand the care process when care needs to be provided efficiently and rapidly. In oncology the administration of both radiation and chemotherapy are considered high risk services. Policies and procedures are important. They help the personnel understand these patients and services and respond in a thorough, competent and uniform manner. The clinical and managerial leaders must take responsibility for identifying the patients and services considered high risk, using a collaborative process to develop policies and procedures and training personnel in their implementation. The special facilities and safety measures required by children need to be specified.

It is particularly important that the policies or procedures indicate:

- How planning will occur
- The documentation required for the care team to work effectively

- Special consent considerations
- Monitoring requirements
- Special qualifications or skills of the personnel involved in the care process
- The resuscitation equipment available and how to use it, including equipment for children

Clinical guidelines should be incorporated in the process because there are several criteria requiring guidelines to be used. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.
Policies and procedures should focus on high risk patients and procedures, e.g.:

a) The care of patients with oncological emergencies, e.g. spinal compression, neutropenic fever, raised intracranial pressure, hypercalcaemia, tumorlysis syndrome, vena cava syndrome
b) The handling of chemotherapy and the prescribing of chemotherapy
c) The handling, use and administration of blood and blood products
d) The care of patients on life support or those who are comatose
e) The care of patients with communicable diseases
f) The care of patients treated with radio-active materials
g) The care of immuno-suppressed patients with cancer
h) The care of patients on dialysis
i) The use of restraint and the care of patients in restraint
j) The care of frail, dependent, elderly patients
k) The care of young, dependent children

Criteria

17.2.3.1 Documented protocols, clinical guidelines or standard operating procedures for identified high risk patients and procedures, which include items (a)-(k) in the standard intent above as a minimum, are available and readily accessible.

17.2.3.2 In-service training is provided to personnel to ensure they understand the intent and content of the policies and procedures.

17.2.4 *Admission or transfer to units providing intensive or specialised services is determined by established criteria.*

Standard Intent

Units or services that provide oncology services are costly and usually have limited space and personnel. Each hospital must establish criteria for identifying those patients who require the level of care provided in such units.
Appropriate individuals from the oncology services must participate in developing these criteria.
The criteria should be used to determine direct entry to the unit, for example directly from the emergency service. The criteria should also be used to authorise transfer into the unit from within or outside the hospital, and in deciding when a patient no longer requires the services of the unit and can be transferred to another level of care.

Criteria

17.2.4.1 The hospital has established entry and/or transfer criteria for its oncology units, to meet specialised patient needs.

17.2.4.2 The criteria are physiological where possible and appropriate.

17.2.4.3 Appropriate individuals are involved in developing the criteria.

17.2.4.4 Personnel are trained to apply the criteria.

17.2.4.5 Patients transferred or admitted to intensive and specialised units/services meet the criteria, as documented in the patient's record.

17.2.4.6 Patients who no longer meet the criteria to remain in the unit are transferred or discharged.

17.3 Assessment of Patients

17.3.1 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

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

Documented hospital policy must define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations. These findings should be used throughout the care process to evaluate patient progress and understand the need for reassessment. It is essential that assessments are documented well and can be easily retrieved from the patient's record.

Hospital policy must define the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings are verified on admission to the hospital.

Criteria

17.3.1.1 Hospital policies and procedures for assessing patients on admission and during ongoing care are implemented.

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

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

17.3.1.4 Assessments are performed within appropriate time frames and are comprehensively documented in the patient's records according to hospital policy.

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

Standard Intent
The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable assistance in these areas of assessment and in understanding the patient's wishes and preferences. Financial factors must be assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.
A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. When appropriate, the assessment process should be modified to respect local cultural practices.

The outcome of the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin. Planning for discharge should be commenced during this initial assessment process.
When the medical assessment was conducted by a different healthcare organisation, a legible copy of the findings must be placed in the patient's record. Any significant changes in the patient's condition since this assessment must be recorded.

Criteria

17.3.2.1 Each patient admitted has an initial assessment according to hospital policy.

17.3.2.2 The initial assessment includes health history.

17.3.2.3 The initial assessment includes physical examination.

17.3.2.4 The initial assessment includes functional and nutritional examination, where applicable.

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

17.3.2.6 The initial assessment includes psychological assessment, where applicable.

17.3.2.7 The initial assessment includes cultural assessment, where applicable.

17.3.2.8 The initial assessment results in an initial diagnosis.

17.3.2.9 The patient's medical, nursing and other healthcare needs identified during the initial assessment are documented.

17.3.3 *Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.*

Standard Intent

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

Criteria

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

17.3.3.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care and used to develop the treatment plan, which includes the goals of care.

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

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

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

Standard Intent

The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy. Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.
The patient, family and others should be included in the decision-making process when appropriate. The patient's record must contain a history of all care provided by the multidisciplinary team and be made available to all relevant caregivers who are authorised to access its content.

Criteria

17.3.4.1 The patient's clinical records are completed according to guidelines determined by the hospital.

17.3.4.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

17.3.4.3 Information exchanged includes a summary of the care provided.

17.3.4.4 Information exchanged includes the patient's progress.

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

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

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

17.4 Patient Care

17.4.1 *The care provided to each patient is planned and documented in the patient's record.*

Standard Intent
A single, integrated care plan is preferable to a separate care plan recorded by each healthcare professional. The care plan should include the care to be delivered and the intended goals of care.
Collaborative care and treatment team meetings or similar patient discussions must be recorded.

Diagnostic and other procedures must be ordered by individuals qualified to do so. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders. The reason for requesting diagnostic imaging or laboratory tests should be recorded if this reason will be required for interpretation of the results of these orders.
The hospital must decide:

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

The method used must respect the confidentiality of patient care information, e.g. order books must not be kept in an area where they can be seen by other patients or visitors and verbal orders, including those given over the telephone, should be taken in an area where they cannot be overheard.

Criteria

17.4.1.1 The planned care is provided and documented in the patient's record.

17.4.1.2 The patient's response to care and therapeutic interventions is documented in the patient record.

17.4.1.3 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

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

17.4.1.5 Reassessments are performed at appropriate, regular intervals and following a change in the patient's condition and documented in the patient's record.

17.4.1.6 Care plans are revised when necessary in response to the findings of reassessments.

17.4.2 *Each healthcare professional supports patient, family and caregiver participation in care decisions and care processes.*

Standard Intent

The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations. Personnel involved in patient, family and caregiver education must collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective.

Education must be focused on the specific knowledge and skills that the patient, family members and caregivers will need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment. It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to remain an in-patient rather than receiving care as an out-patient.

Information relating to the planning and delivery of education must be recorded in a consistent location in the patient record and follow a standardised format. Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

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

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

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

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

17.4.3 *Adequate information is provided when obtaining informed consent from patients or their legal representatives*

Standard Intent
Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.
The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

- Discussion of the patient's diagnosis and why the procedure is advised
- The expected benefits of the procedure
- The likelihood of success of the procedure
- A thorough explanation of the proposed procedure
- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure
- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent
- How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g. learning difficulties) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families. The leaders must agree and implement a process for the documentation of verbal consent.

Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.

Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent, to ensure that they are fully aware of hospital requirements. Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure. Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure.

Criteria

17.4.3.1 There is a documented process for obtaining or confirming informed consent.

17.4.3.2 Consent forms or the form confirming consent are completed comprehensively and available in-patient records.

17.4.3.3 Verbal consent is obtained and recorded according to hospital policy.

17.4.4 *Pre-and post-procedural assessments are documented.*

Standard Intent

Medical care may include invasive procedures related to the medical condition, e.g. cardiac catheterisation and other interventional radiological procedures, endoscopy, biopsy, etc. The management of these interventions is considered in this section of the standards.
The pre-anaesthetic medical assessment determines whether the patient's medical condition is stable enough to allow for surgical intervention or the planned procedure and may significantly influence the pre- and intraprocedural management of the patient. All information regarding the medical assessment, investigation, treatment and review of the patient must be available to the doctor performing the anaesthetic assessment.
A patient's post-procedural care at ward level is related to the procedure itself and the findings of the procedure. The report of the procedure must be available within an acceptable time frame to provide appropriate ongoing care on the ward following the procedure. Results of monitoring influence intra- and post-procedural decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

Criteria

17.4.4.1 The patient's pre-anaesthetic medical assessment to determine fitness for anaesthesia is documented.

17.4.4.2 Patients have a pre-procedural diagnosis recorded before anaesthesia.

17.4.4.3 A post-procedural diagnosis is documented.

17.4.4.4 The name of the medical practitioner responsible for the procedure is documented.

17.4.4.5 The patient's physiological status is monitored during the post-procedural period.

17.4.5 *The hospital implements processes to support the patient in managing pain.*

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

To ensure that this right is implemented, the hospital develops processes to:

- Identify patients with pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

17.4.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

17.4.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

17.4.6 *The hospital develops processes to manage end-of-life care.*

Standard Intent
Dying patients have unique needs for respectful and compassionate care. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life. Wherever possible the patient and family should be included in the discussions regarding the plan of care and fully understand the reasons why specific decisions are taken.
To accomplish this, all personnel must be made aware of the unique needs of patients at the end of life. These needs include treatment of primary and secondary symptoms, pain management, responding to the concerns of the patient and their family and involving them in care decisions.

End-of-life care provided by the hospital should include:
a) Providing appropriate treatment for any symptoms according to the wishes of the patient and family
b) Sensitively addressing issues such as autopsy and organ donation
c) Involving the patient and family in all aspects of care to support them in making informed decisions on any proposed changes to the plan of care, where appropriate
d) Responding respectfully to the psychological, emotional, spiritual, religious and cultural concerns of the patient and family by providing information that is honest and truthful as identified for their needs

Criteria

17.4.6.1 Policies and procedures regarding end-of-life care, which include (a)-(d) in the standard intent above as a minimum, are implemented.

17.4.6.2 The patient, family and significant other(s) are involved in care decisions.

17.4.6.3 Pain and primary or secondary symptoms are managed according to hospital policy.

17.4.6.4 Religious and cultural needs of patients and their families or significant others are identified and met.

17.5 Medication and Chemotherapy Management

17.5.1 *Medication and chemotherapy use in the hospital complies with applicable Namibian laws and regulations.*

Standard Intent
Medication and chemotherapy management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel participate in a collaborative process to develop and monitor policies and procedures.
Each hospital has a responsibility to identify those individuals with the requisite knowledge and experience and who are permitted by Namibian law, registration or regulations to prescribe or order medication and chemotherapy. In emergency situations, the hospital identifies any additional individuals permitted to prescribe or order medication (inclusive of anti-emetic drugs and analgesics).
Requirements for the documentation of medication ordered or prescribed and for the use of verbal medication orders are defined in policy.
The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters, etc.

Criteria

17.5.1.1 Policies and procedures that guide the safe prescribing, ordering and administration of medication and chemotherapy are implemented.

17.5.1.2 The use of verbal/telephonic medication orders is documented according to hospital policy.

17.5.1.3 Only those permitted by the hospital and by relevant laws and regulations prescribe medication and chemotherapy.

17.5.1.4 Medication, including herbal and over-the- counter medication, brought into the hospital by the patient or the family is known to the patient's medical practitioner and is noted in the patient's record.

17.5.2 *Medication and chemotherapy are safely administered.*

Standard Intent

Only personnel who are suitably trained and experienced may administer medication and chemotherapy to patients. The responsibility of these persons for medication and chemotherapy administration must be documented. The safe administration of medication requires a strict and comprehensive protocol. Policies for patient preparation and work-up must be implemented prior to each chemotherapy treatment to prevent adverse events.

The patient, physician, nurse and other care providers must work together to monitor patients on medication and chemotherapy. The purposes of monitoring are to evaluate the response to medication and chemotherapy, adjust the dosage or type of medication/chemotherapy when needed and to evaluate the patient for adverse effects.

The hospital must follow Namibian requirements for the reporting of adverse effects.

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

In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be helpful in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

17.5.2.1 Only those permitted by the hospital and by relevant laws and regulations administer medication/chemotherapy.

17.5.2.2 There is evidence that patients are identified before medication is administered.

17.5.2.3 Medication/chemotherapy is checked against the original prescriptions and administered as prescribed.

17.5.2.4 Healthcare professionals monitor medication/chemotherapy effects on patients collaboratively.

17.5.2.5 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

17.5.2.6 Medication errors are reported through a process and within a time frame defined by the hospital.

17.5.2.7 The medication/chemotherapy prescribed for and administered to each patient is recorded.

17.5.3 *Medication/chemotherapy is stored in a safe and clean environment.*

Standard Intent
Patient care units store medication/chemotherapy in a clean and safe environment that complies with Namibian laws, regulations and professional practice standards.

Criteria

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

17.5.3.2 Medication identified for special control (by law or hospital policy) is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

17.5.3.3 Medication identified for special control (by law or hospital policy) is accurately accounted for.

17.5.3.4 Medication/chemotherapy agents are securely and legibly labelled with relevant information as required by law and hospital policy.

17.5.3.5 Medication/chemotherapy is stored in a clean environment.

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

17.5.3.7 A refrigerator is available for medication/chemotherapy requiring storage at low temperatures.

17.5.3.8 The temperature of the refrigerator is monitored and recorded.

17.5.3.9 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

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

17.5.3.11 Chemotherapy preparation is undertaken with protective gear and in an appropriate environment to protect the workers against possible adverse effects.

17.6 Food and Nutrition Therapy

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

Standard Intent
A qualified caregiver should order appropriate food or other nutritional substitutes. The patient should participate in planning and selecting food. The patient's family may participate in providing food when appropriate. When they do, they must be educated as to which foods are contraindicated in the patient's clinical condition and potential interactions between certain food and medication where relevant. When possible, patients should be offered a variety of food choices consistent with their nutritional status. The nutritional status of the patients must be monitored.

Criteria

17.6.1.1 Food appropriate to the patient is regularly available.

17.6.1.2 Food orders appropriate for the patient's nutritional status and needs are documented in the patient's record.

17.6.1.3 Wherever possible, patient food preferences are respected and substitutions made available.

17.6.1.4 When families provide food, they are educated about the patient's dietary limitations.

17.6.1.5 Patients assessed as being at nutritional risk receive nutrition therapy.

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

17.6.1.7 Nutrition therapy provided, whether oral, enteral or parenteral, is documented in the patient's record.

17.6.1.8 Response to nutrition therapy is monitored and recorded.

17.7 Continuity of Care

17.7.1 *The hospital designs and carries out processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent
As patients move through a healthcare organisation from admission to discharge or transfer, several departments, services and healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission are more likely to occur, exposing the patient to avoidable risks. The hospital should document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

17.7.1.1 Policies and procedures that guide the movement of patients within the hospital are implemented.

17.7.1.2 Individuals responsible for the patient's care and its coordination are identified for all phases of patient care.

17.7.1.3 Continuity and coordination are evident throughout all phases of patient care.

17.7.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

17.7.1.5 Patient handover between healthcare professionals is standardised according to hospital policy.

17.7.2 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent
Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare facility only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral facility) or while under the care of the outpatient department. Hospital policy must clearly describe this referral process.

Criteria

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

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

17.7.2.3 Follow-up care based on the findings of investigations and/or consultations performed outside the referring hospital is documented in the patient record.

17.7.3 *There is a process to transfer patients to another healthcare organisation to meet their continuing needs.*

Standard Intent
This standard refers to the process by which a patient is discharged from the transferring hospital and handed over to receive ongoing care at another healthcare organisation, i.e. the facility receiving the transferred patient. Transfer may be to a higher level of care for specialised treatment, or for less intensive services such as sub-acute care or long-term rehabilitation.

To ensure continuity of care, adequate information must accompany the patient. Transfer may be an uncomplicated process with the patient alert and talking or may involve continuous nursing or medical supervision. The process for transferring the patient must consider transportation needs as well as clinical needs. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer. The process for transferring the patient must consider transportation needs as well as clinical needs.

Criteria

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

17.7.3.2 When a patient is transferred to another healthcare organisation, the receiving organisation is given a written summary of the patient's clinical condition and the interventions performed by the referring (transferring) hospital.

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

17.7.3.4 The healthcare organisation agreeing to receive the patient is documented in the patient's record.

17.7.4 *There is an organised process to discharge patients.*

Standard Intent

Care planning should include arrangements to meet the patient's continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing. The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The discharge summary must contain the following content as a minimum:

a) The diagnosis of main and significant illnesses
b) The results of investigations that will influence further management
c) All procedures performed
d) The patient's condition at discharge
e) Discharge medication
f) Follow-up arrangements where appropriate, including emergency review

Criteria

17.7.4.1 There is a documented process to discharge patients.

17.7.4.2 Where the initial assessment indicates that discharge planning will be required, planning requirements are included in the patient's care plan and completed as scheduled.

17.7.4.3 The hospital works with the family, caregivers, healthcare practitioners and agencies outside the hospital to ensure timely and appropriate discharge.

17.7.4.4 Patients and where appropriate their families or caregivers are given understandable follow-up instructions which are documented in the patient's record.

17.7.4.5 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

17.7.4.6 Each record contains a copy of the discharge summary.

17.8 Quality Improvement

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

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team ensures that standards are set throughout the hospital. Within each department or service, unit managers ensure that standards are set for the particular unit. Departmental or service managers use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structures to ensure coordinated quality improvement activities throughout the hospital.

Quality monitoring is typically applied to high risk, high volume or high cost activities, or areas of concern identified by personnel, patients or visitors. Some examples of activities that may benefit from quality monitoring include:
a) Patient assessment
b) Procedures carried out
c) The use of antibiotics and other medication
d) Medication errors
e) The use of blood and blood products
f) Patient and family expectations and satisfaction
g) Monitoring turnaround times for investigations requested

The following will be evaluated:
- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC.
Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

17.8.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

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

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

17.8.1.4 A documentation audit system is in place.

17.9 Patient Rights

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

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4).

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

Criteria

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

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

17.9.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

17.10 Prevention and Control of Infection

17.10.1 *The department/service implements infection prevention and control processes.*

Standard Intent

This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

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

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

17.10.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

17.10.1.7 Infection control processes include safe injection practices, including single-use injection devices.

17.10.1.8 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

17.11 Risk Management

17.11.1 *The department/service implements risk management processes.*

Standard Intent

This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

17.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

17.11.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

17.11.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

17.11.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

17.11.1.5 Fire safety measures are implemented.

17.11.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

18 Emergency Care

OVERVIEW OF EMERGENCY CARE

Emergency care is provided at many different levels, from primary healthcare units to large university referral hospitals and clearly the expectations in terms of expertise and equipment are different. Most emergency units form part of a larger organisation, usually a hospital, which is responsible for certain management and administrative functions, e.g. human resource and supply chain management.

Trauma and emergency services are best delivered when institutions form part of a trauma/emergency system rather than operating as independent, uncoordinated elements. In order to plan a system, the capabilities of individual organisations need to be catalogued. This information is then used to inform medical transport services of the level of care available at each facility which will then dictate the appropriate destination facility for each patient. This information will also be useful in the development of system-wide disaster plans. The standards provide a tool to achieve this as well as providing a systematic measurement of management, training and equipment shortfalls so that scarce resources can be allocated as efficiently as possible.

Although optimisation of the physical environment is an important goal, excellent care can be provided with limited resources. Proper training, personnel support and functional administrative structures are the most important priorities in the provision of quality emergency services.

18.1 Facilities and Equipment

18.1.1 *Adequate resources are available for the provision of safe care to patients in the unit.*

Standard Intent

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

Emergency call systems must be available in emergency care areas, at bedsides and in ablution facilities and connected to the emergency power supply.

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

Criteria

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

18.1.1.2 Facilities allow privacy when providing personal information or undergoing examination or procedures.

18.1.1.3 Electricity and water are available in accordance with the hospital's arrangements.

18.1.1.4 There is a waiting area for patients and families.

18.1.1.5 There is adequate seating in the waiting area.

18.1.1.6 Wheelchair-accessible toilets are available.

18.1.1.7 Quiet and private areas are available for waiting relatives and grieving or otherwise distressed relatives or carers.

18.1.1.8 There is access to a functioning telephone facility for use by the public.

18.1.2 *Clinical areas within the emergency unit are adequate to meet the needs of patients.*

Standard Intent

In situations of limited resources most emergency units will not be located in a modern, purpose-built facility. However, the clinical areas may be arranged in a way that assists management of the most critical patients. For instance, there should be a designated resuscitation area situated in close proximity to the ambulance entrance.

The arrival of critical patients may be unpredictable, particularly in regions where patients use unofficial emergency transport and there must be an alarm system, audible in the personnel rest areas, to indicate the arrival of a critical patient.

Major and regional units should be equipped with a decontamination area for the management of patients exposed to hazardous materials which:

- Is in close proximity to the ambulance entrance
- Provides for patient privacy
- Has a raised barrier to protect personnel
- Is spacious enough for patient and personnel
- Has good water run off such that contaminated material can be collected and isolated

Operating theatre facilities may be located on a different floor, in which case there must be a lift override mechanism. Comprehensive trauma and emergency care will require inpatient care for most major cases.

Criteria

18.1.2.1 There is a designated triage area.

18.1.2.2 There is a designated resuscitation area.

18.1.2.3 There is a mechanism for summoning medical help in an emergency.

18.1.2.4 Oxygen and vacuum supplies meet patient care needs.

18.1.2.5 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

18.1.2.6 There is adequate storage space to enable rapid retrieval and removal of equipment when needed.

18.1.2.7 There is evidence that equipment is maintained in accordance with the policies of the hospital.

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

18.1.2.9 There is a low pressure, hand-held shower suitable for the management of patients contaminated with hazardous materials.

18.1.2.10 There is access to inpatient facilities consistent with the level of emergency care.

18.1.2.11 There is easy access to the operating theatre.

18.1.3 *Resuscitation equipment is available in accordance with the policies of the hospital.*

Standard Intent
Resuscitation equipment must be available in the unit and must be checked in accordance with the hospital's resuscitation policy. Checking must include expiry dates on medication and consumables such as airways and endotracheal tubes. Documented evidence of this checking is required.

Resuscitation trollies and defibrillators or automated external defibrillators (AED) should be available in the department in accordance with the level of services provided.

It is important to carry a range of adult and paediatric size equipment and a reasonable selection within each range. Namibian arrangements will apply.

Resuscitation equipment should include at least:
a) A defibrillator with adult paddles/pads (and infant paddles/pads where applicable)
b) An ECG monitor
c) A CPR board (if required)
d) Suction apparatus (electrical and/or alternative) plus range of soft and hard suction catheters
e) Bag-mask manual ventilators in an appropriate number to suit the size of the facility
f) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
g) An introducer/stylet for endotracheal intubation
h) A syringe to inflate the ETT cuff
i) Oropharyngeal tubes
j) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
k) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
l) Drugs for cardiac arrest, coma, fits and states of shock (including paediatric doses where applicable).

Criteria

18.1.3.1 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

18.1.3.2 Recommended appliances are available for specialised resuscitations.

18.1.3.3 Diagnostic and vital sign monitoring equipment is available as per hospital policy.

18.1.4 *There is a rest area for personnel in close proximity to the clinical areas.*

Standard Intent
Rest areas for personnel should be adequately equipped to allow personnel to remain in the vicinity of the department at all times. The type of facilities provided will vary and will depend on the length of shifts undertaken and access to other refreshment facilities in close proximity to the department.

Criteria

18.1.4.1 There is an adequately equipped kitchen, with at least a kettle, toaster and microwave.

18.1.4.2 There are rest room facilities for personnel including a changing area, toilet and hand washing facilities.

18.1.4.3 Where personnel undertake 24-hour shifts, there are sleeping and shower facilities.

18.1.4.4 The rest area is equipped with a telephone or intercom system.

18.2 Patient Registers

18.2.1 *Patient registers are kept in accordance with Namibian requirements and/or hospital policy.*

Standard Intent
Hospitals may be required by Namibian law and regulation to maintain registers of patients attending the emergency unit and patients receiving radiological investigations. Attendance registers should include mode of arrival, time of arrival, name, date, treatment administered and information on final disposition (admission, discharge, death or transfer).

Criteria

18.2.1.1 A register is kept of patients attending the emergency unit.

18.2.1.2 The register contains at least the patient's name, patient-specific identification number, age, gender date and time of admission, treatment, procedures, discharge, referral or death.

18.2.1.3 The information in the register is used to monitor waiting periods from time of arrival to time of assessment.

18.3 Service Management

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

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

Criteria

18.3.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

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

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

18.3.1.5 During the hours of operation there is an adequate number of qualified professionals available to provide continuous cover to all sections at all times.

18.3.1.6 Emergency services personnel maintain skills in advanced life support in accordance with hospital policy.

18.3.1.7 Medical cover is reflected on a roster and each practitioner on the roster is contactable by telephone, pager or other two-way communication method.

18.3.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable variation.*

Standard Intent
Clinical practice guidelines provide a means for improving quality and assist practitioners in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged, e.g. hepatitis E in a non-endemic area.

Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the clinical leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines are reviewed on a regular basis to ensure their continued relevance.

Criteria

18.3.2.1 Evidence-based clinical practice guidelines, relevant to the patients and services of the hospital, are available to guide patient care processes.

18.3.2.2 Clinical practice guidelines include protocols for time-critical states.

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

18.3.2.4 Guidelines are reviewed and adapted on a regular basis.

18.4 Visitor Control

18.4.1 *A system of visitor control is maintained to ensure the safety of patients and personnel.*

Standard Intent
Controlling visitors' access to the unit is important, not only as a security precaution but also because anxious relatives in clinical areas can impede delivery of services. Additionally, community emergencies, VIP admissions and other newsworthy events may lead to invasion by the media. Policies should be available to guide all personnel, but clerical and security personnel are particularly important in implementing visitor control.

Criteria

18.4.1.1 The hospital's policy on visitors to the emergency unit is implemented.

18.4.1.2 There is a system to inform patients and family of the visitors' policy.

18.4.1.3 Areas where access is denied to persons other than personnel are clearly marked.

18.4.1.4 The discretionary powers of personnel in charge of the service relating to visitors under special circumstances are documented.

18.4.1.5 Policies regarding media invasion are implemented to guide clinical and security personnel.

18.5 Assessment of Patients

18.5.1 *The hospital has a formal triage process which uses documented guidelines to determine urgency*

Standard Intent
This standard refers to initial triage by either a medical practitioner or registered nurse. In urgent cases, initial management will take place simultaneously with assessment. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the hospital.

It is essential that triage assessments are properly documented, legible and easily retrieved from the patient's record.

Following the triage assessment, patients should see the relevant professional within appropriate time frames established by the professional societies or hospital policy, e.g.
Red Patients: Immediate
Orange Patients: Less than 20 minutes
Yellow Patients: Less than 60 minutes
Green Patients: Less than 240 minutes

An internationally acceptable evidence-based method of patient triage must be implemented.

All personnel responsible for patient triage are trained in the triage process selected for implementation in the unit.

Criteria

18.5.1.1 The unit implements an evidence-based triage system.

18.5.1.2

18.5.1.3 All personnel responsible for patient triage have received training in the application of the triage system.

18.5.1.4

18.5.1.5 Clinical records of emergency patients include the time of arrival.

18.5.1.6

18.5.1.7 The triage category for each patient is recorded.

18.5.1.8 Clinical records of emergency patients include time of referral to medical practitioner.

18.5.1.9 Waiting times from triage categorisation to initial assessment are monitored.

18.5.2 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent
When a patient enters the Emergency Unit, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being

provided. Assessments must be completed with due regard to privacy. This is particularly important when the patient is a victim of social or sexual violence.
The hospital should define in writing the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations. The hospital should determine the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the hospital.
The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable assistance in these areas of assessment and in understanding the patient's wishes and preferences. Financial factors should be assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.
A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process should be modified in accordance with local custom.
The outcome from the patient's initial assessment should result in an understanding of the patient's medical and nursing needs so that care and treatment can begin. When the medical assessment was conducted outside the hospital, a legible copy of the findings must be filed in the patient's record. Any significant changes in the patient's condition since this assessment should be recorded.

Psychiatric patients may present acutely to emergency units with conditions that cannot be managed effectively in this setting. In these instances, access to appropriate care can be expedited by means of a standing agreement developed collaboratively between the emergency unit and the nearest psychiatric unit. A formal agreement with clearly defined referral pathways can be of benefit in these situations to expedite the patient's access to appropriate services.

Criteria

18.5.2.1 The hospital implements policies and procedures for assessing patients on admission and during ongoing care.

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

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

18.5.2.4 Assessments are performed within appropriate time frames and are comprehensively documented in the patient's records according to hospital policy.

18.5.2.5 Agreements are in place with the nearest psychiatric unit to ensure appropriate, expedited care for psychiatric patients.

18.6 Diagnostic Services

18.6.1 *Diagnostic imaging services are available to meet patient needs.*

Standard Intent
The hospital's leaders must ensure that appropriate diagnostic imaging facilities are available, that radiation safety programmes are in place and that individuals with adequate training, skills, orientation and experience are available to undertake diagnostic imaging procedures and interpret the results.

The diagnostic imaging service must allow for immediate decision-making by practitioners through the provision of emergency services and the provision of emergency reports, as necessary.

Criteria

18.6.1.1 Adequate and convenient diagnostic imaging services are available at all times.

18.6.1.2 Established waiting times for diagnostic imaging studies to be done according to triage status are monitored.

18.6.1.3 Established waiting times for diagnostic images to be available are monitored.

18.6.1.4 Where X-rays are initially interpreted by emergency unit medical personnel, there is a system for review by appropriately qualified diagnostic imaging personnel, when required.

18.6.2 *The emergency unit is supported by adequate clinical laboratory services.*

Standard Intent

Laboratory services, including those required for emergencies and after-hours services, may be provided within the hospital, by agreement with another hospital, or both if outside sources are convenient for the patient to access. Whatever the arrangement, it is expected that laboratory services will be available continuously and should be on site or in close proximity to the emergency unit.

Point of care or bedside tests can be performed within the emergency department by non-laboratory personnel and give rapid results. They are particularly important where laboratory facilities are not available on the premises; transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the emergency unit. Determination of blood glucose, finger-prick haemoglobin or haematocrit testing and urine testing are considered essential for an emergency department. Centres in areas where malaria is endemic or where tourists are frequently seen, should also have rapid, antigen-based tests for the diagnosis of Falciparum malaria. Training and quality control are required for all point of care tests.

The majority of urgent clinical decisions can be made based on the results of point of care testing outlined above. However, emergency units require urgent laboratory services for the provision of specialised testing.

Criteria

18.6.2.1 Laboratory services are available at all times.

18.6.2.2 Established waiting times for laboratory tests to be done according to triage status are monitored.

18.6.2.3 Established waiting times for laboratory results to be available are monitored.

18.7 Patient Care

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

Standard Intent

The coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by hospital policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to improve integration and coordination care for their patients (for example, team-delivered care, integrated patient records, and case managers).Policies and

procedures should describe standardised handover procedures to be followed when receiving patients from or transferring patients to the ambulance service and wards, as well as when handing over to a new shift. As a minimum, handovers between shifts in the emergency department should include formal handover of patients triaged into categories requiring immediate or urgent medical attention.

Standardisation of this process reduces variability in the information exchanged, thereby reducing the likelihood that important information is omitted in the handover process.

The World Health Organisation recommends the SBAR approach (Situation, Background, Assessment, Recommendation).
http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf
The patient, family and others should be included in the decision-making process when appropriate. The patient's record must contain a history of all care provided by the multidisciplinary/interdisciplinary team and be made available to all relevant care providers who are authorised to have access to its content.

Criteria

18.7.1.1 The patient's clinical records are completed according to guidelines determined by the hospital.

18.7.1.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

18.7.1.3 Information exchanged includes a summary of the initial assessment, subsequent care provided and the results of diagnostic tests.

18.7.1.4 Information exchanged includes the patient's progress.

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

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

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

18.7.1.8 Patient handover between healthcare professionals is standardised according to hospital policy.

18.7.2 *Adequate information is provided when obtaining informed consent from patients or their legal representatives.*

Standard Intent

Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.
The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

- Discussion of the patient's diagnosis and why the procedure is advised
- The expected benefits of the procedure
- The likelihood of success of the procedure
- A thorough explanation of the proposed procedure
- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure

- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent
- How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g. delirium, learning difficulties, etc.) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.
The leaders must agree and implement a process for the documentation of verbal consent. Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.
Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements.
Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure.
Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. Where permissible according to Namibian legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

18.7.2.1 There is a documented process for obtaining or confirming informed consent.

18.7.2.2 Consent forms or the form confirming consent are completed comprehensively and available in-patient records.

18.7.2.3

18.7.2.4 Verbal consent is obtained and recorded according to hospital policy.

18.7.3 *Invasive procedures and minor operations performed in the emergency unit are controlled by policy.*

Standard Intent

Patients attending the emergency unit may require invasive procedures such as central venous cannulation or tube thoracotomy. Policies and procedures must define who should perform these procedures, for what indications and under what conditions, ensure that they are performed based on clinical need and meet infection control requirements.
Persons performing invasive procedures must be appropriately trained.
Adverse events resulting from invasive procedures should be documented and investigated and appropriate steps taken to prevent recurrence or minimise harm in the event of a recurrence.

Criteria

18.7.3.1 Policies and procedures govern invasive procedures performed in the emergency department.

18.7.3.2 Protocols guide medication use for sedation, pain and anaesthesia.

18.7.3.3 Protocols address appropriate monitoring during and after the procedure.

18.7.3.4 The procedure and the name of the person performing the procedure are recorded in the patient's record.

18.7.3.5 Unsuccessful or complicated procedures are recorded.

18.7.4 *Patients being transferred from the Emergency Unit to the operating theatre are appropriately prepared.*

Standard Intent
For a successful surgical outcome, patients being transferred to the operating theatre may require prior optimisation of their medical condition. This need is assessed in the context of their current illness or injury: in the case of active bleeding, for example, surgery may be the intervention required to normalise the physiological state and pre-operative resuscitation may be fruitless. In cases of lower surgical acuity, particularly in patients with comorbid pathologies, proper assessment and preparation will improve the outcome.
In addition to optimisation of the patient's physical condition, pre-operative preparation also includes washing and interventions such as catheterisation and intravenous cannulation. Policies should address responsibility for this.
Results of diagnostic tests must be available to the surgical and anaesthetic teams in the operating theatre. Patients requiring emergency surgery are at risk of decompensation if they are left unattended in an operating department holding area and an appropriately qualified person should accompany them, the level of qualification depending on the patient's needs. This person is also responsible for handing over to the operating department team.

Criteria
18.7.4.1 The indication for surgery is recorded before anaesthesia.

18.7.4.2 Policies that address nursing preparation of patients being transferred to the operating theatre are implemented.

18.7.4.3 Patients being transferred to the operating theatre are accompanied by an appropriately qualified person, as determined by hospital policy.

18.7.5 *Post-operative assessments are documented.*

Standard Intent
A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report must be available within a time frame needed to provide post-surgical care to the patient.
Post-operative monitoring must be appropriate to the patient's condition and the procedure performed. Results of monitoring should influence intra- and post-operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

Criteria
18.7.5.1 A post-operative diagnosis is documented.

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

18.7.5.3 The patient's physiological status is monitored during the immediate post-surgical period.

18.7.6 *The hospital implements processes to support the patient in managing pain.*

Standard Intent
To ensure that this right is implemented, the hospital develops processes to:

- Identify patients with pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

18.7.6.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

18.7.6.5 The hospital has processes to educate health professionals in assessing and managing pain.

18.7.7 *There is access to emergency blood and blood products in accordance with hospital policy.*

Standard Intent
Hospitals should have emergency blood on site with access to banked blood within one hour.
It is recommended that hospitals have two to four units of blood on site.
The type and amount of emergency blood and blood products to be kept on site will be determined by hospital policy.

Criteria

18.7.7.1 Emergency blood is available at all times.

18.7.7.2 There is a designated refrigerator for emergency blood and blood products.

18.7.7.3 The temperature of the refrigerator is monitored and recorded according to hospital policy.

18.7.7.4 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

18.7.7.5 Banked emergency blood is subject to stock control, which includes the replacement of stock before its expiry date.

18.8 Medication Management

18.8.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent

Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards.

Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction. "Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary. Doors, hinges and seals must all be functional.

Criteria

18.8.1.1 Medication is ordered according to hospital policy.

18.8.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

18.8.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

18.8.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

18.8.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

18.8.1.7 Medication is stored in a clean environment.

18.8.1.8 A dedicated refrigerator is available for medication requiring storage at low temperatures.

18.8.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

18.8.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

18.8.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

18.8.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel should participate in a collaborative process to develop and monitor policies and procedures. Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy. The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters, etc. Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant.

The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed. In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

18.8.2.1 Policies and procedures that guide the safe prescribing, dispensing and administration of medication are implemented.

18.8.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

18.8.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

18.8.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

18.8.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

18.8.2.6 There is evidence that patients are identified before medication is administered.

18.8.2.7 Medication is checked against the original prescriptions and administered as prescribed.

18.8.2.8 The medication prescribed for and administered to each patient is recorded.

18.8.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

18.8.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

18.8.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

18.9 Patient and Family Education

18.9.1 *Education supports patient and family participation in care decisions and care processes.*

Standard Intent

The hospital must select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations. Personnel involved in patient, family and caregiver education must collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective. Education must be focused on the specific knowledge and skills that the patient, family members and caregivers will need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.

It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to be admitted rather than receiving care as an outpatient.

Information relating to the planning and delivery of education must be recorded in a consistent location in the patient record and follow a standardised format. Community organisations that support health promotion and disease prevention education should be identified and when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

18.9.1.1 Patients and families indicate that they have received health education appropriate to their condition.

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

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

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

18.10 Continuity of Care

18.10.1 *The hospital designs and carries out processes to provide continuity of patient care*
18.10.2 *services within the hospital and coordination amount health professionals.*

Standard Intent
As patients move through a hospital from admission to discharge or transfer, several departments and services and many different healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks. The hospital must document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

18.10.2.1 Established criteria or policies that determine the appropriateness of transfers within the hospital are implemented.

18.10.2.2 Individuals responsible for the patient's care and its coordination are identified for all phases.

18.10.2.3 Continuity and coordination are evident throughout all phases of patient care.

18.10.2.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

18.10.3 *The hospital implements policies for the management of patients requiring short-*
18.10.4 *term observation and care.*

Standard Intent
Where emergency units have short-stay facilities, also known as admission/overnight or observation facilities, they should be controlled by policies which address:

- Which cases may appropriately be observed in the emergency unit rather than in inpatient facilities
- Who is responsible for the patient
- Timing of medical reassessment
- Length of stay
- Provision of refreshments/meals

The facilities should be adequate for safe medical care and medical records should clearly state the parameters under observation and actions to be taken should these parameters change.

Criteria

18.10.4.1 Policies and procedures that address the holding of patients for observation are implemented.

18.10.4.2 The hospital has established appropriate time frames which limit holding time in the emergency unit.

18.10.4.3 Patients under observation are reassessed at appropriate intervals to determine their response to care and treatment and this is documented in the record.

18.10.4.4 Any significant changes in the patient's condition are noted in the patient's record and acted upon appropriately.

18.10.4.5 Any patient care meetings or other discussions are noted in the patient's record.

18.10.4.6 Holding times are monitored and audited.

18.10.5 *There is a process for admitting patients to inpatient facilities.*

Standard Intent
The time that patients spend waiting for transfer to inpatient facilities should be minimised. Not only is this in the interest of patients' comfort and definitive management, but long holding times have a significant impact on the functioning of the emergency unit by utilising space, resources and nursing time. Admission delays are often the result of system failures and processes should be designed to overcome these failures.

The emergency unit can become congested when there is a lack of inpatient beds. Certain strategies may be implemented to manage inpatient beds more efficiently, such as more frequent consultant ward rounds and a so-called "escalation policy" can be developed in advance to address periods of particular overcrowding with inpatient personnel.

Criteria

18.10.5.1 There is a process known to personnel for admitting patients to the hospital.

18.10.5.2 The unit which accepts the patient for admission is noted in the patient record.

18.10.5.3 The time that the patient is accepted to the inpatient unit and the time the patient is transferred are documented in the patient record.

18.10.5.4 Holding times in the unit while awaiting transfer are monitored.

18.10.5.5 Policies and procedures that address the management of patients when bed space is not available in the desired service or unit or elsewhere in the hospital are implemented.

18.10.6 *There is a process known to personnel to refer patients for specialised consultation, investigations and/or treatment at other healthcare organisations.*

Standard Intent
Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, to access more extensive diagnostic evaluations than may be available locally, or to access specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare organisation only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral hospital) or while under the care of the outpatient department. Hospital policy must clearly describe this referral process.

Criteria

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

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

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

18.10.7 *There is a process to transfer patients to another healthcare organisation to meet their continuing needs.*

Standard Intent

Transfer may be for specialised consultation or investigation at another healthcare organisation for treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation. To ensure continuity of care, adequate information must accompany the patient. Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer. The process for transferring the patient must consider transportation needs.

Patients may require transfer to another healthcare organisation, either to address their ongoing needs more appropriately, or because of patient or family choice or financial concerns. However, all patients who require resuscitation and stabilisation must receive such care prior to transfer.

In a well-organised system, the capabilities of individual hospitals will be catalogued and coordinated, so that arrangements will already exist with units to which the hospital frequently refers. When transfer criteria and processes are formally agreed in advance, patients are more likely to receive appropriate emergency care when their needs exceed the capabilities of the hospital.

Appropriate information should accompany the patient, including at least:

- The reason for transfer
- Any special conditions related to transfer
- The condition of the patient before transfer
- Any interventions provided by the referring hospital

Criteria

18.10.7.1 There is a documented process for transferring patients to other healthcare organisations for specialised and support services.

18.10.7.2 Patients are stabilised according to appropriate clinical guidelines prior to transfer.

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

18.10.7.4 The process for transferring the patient considers transportation needs.

18.10.7.5 A policy that requires the responsible clinician to communicate the level of care required to Emergency Medical (ambulance) services is implemented.

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

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

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

18.10.7.9 The hospital agreeing to receive the patient is noted in the patient's record.

18.10.8 *There is an organised process to discharge patients who are being treated and*
18.10.9 *released.*

Standard Intent
Care planning should include arrangements to meet the patient's continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing. The discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability. At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs.
This process is referred to as "safety-netting". The discharge summary must contain the following content as a minimum:

a) The reason for admission
b) The diagnosis of main and significant illnesses
c) The results of investigations that will influence further management
d) All procedures performed
e) The patient's condition at discharge
f) Discharge medication
g) Follow-up arrangements where appropriate, including emergency review

Criteria

18.10.9.1 There is a documented process to discharge patients.

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

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

18.10.9.4 A discharge summary, which includes (a)-(g) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

18.10.9.5 Each record contains a copy of the discharge summary.

18.11 Ambulance Services

18.11.1 *Where the hospital provides an ambulance service, this service is delivered in line with relevant Namibian laws and regulations.*

Standard Intent

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

Criteria

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

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

18.11.1.3 The hospital designs and implements processes to provide coordination of services among other hospitals and agencies in the community.

18.11.1.4 The individuals who provide patient care in the ambulance service have the required training and experience.

18.11.1.5 The individuals responsible for management of the ambulance service develop a list of the equipment required for each ambulance in collaboration with other relevant services.

18.11.1.6 The hospital plans and implements processes for inspecting, testing and maintaining equipment and supplies.

18.11.1.7 The hospital maintains its ambulance vehicles to reduce risk and promote safety.

18.11.1.8 Medical transport/ambulance vehicles are cleaned in accordance with hospital policy.

18.12 Quality Improvement

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

Standard Intent

This refers to the implementation of hospital quality improvement processes (Service Element 7).
It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality improvement structures. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.
Quality monitoring could include:

- Patient assessment
- Resuscitation interventions
- Surgical procedures carried out
- The use of antibiotics and other medication and medication errors
- The use of anaesthesia
- The use of blood and blood products
- Waiting times
- Patient and family expectations and satisfaction. The following will be evaluated:
- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement

- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment, will be scored NC.
Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

Criteria

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

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

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

18.12.1.4 A documentation audit system is in place.

18.13 Patient Rights

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

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4).
Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

18.13.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

18.14 Prevention and Control of Infection

18.14.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

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

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

18.14.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

18.14.1.7 Infection control processes include safe injection practices, including single-use injection devices.

18.14.1.8 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

18.15 Risk Management

18.15.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

18.15.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

18.15.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

18.15.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

18.15.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

18.15.1.5 Fire safety measures are implemented.

18.15.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

19 Outpatient Care

OVERVIEW OF OUTPATIENT CARE

Outpatient care may be an integral part of the continuum of care provided before or after a period of hospitalisation, or may be provided to a patient who is referred from a community-based hospital. In some hospitals, outpatient care may be considered an independent, comprehensive service encompassing all outpatient visits.

The World Health Organisation (WHO) has outlined a framework for primary health care, which includes preventive, promotive, curative, rehabilitative and supportive components. Community health service programmes encompass these five components, within the continuum of health care for local communities. A comprehensive referral network with other community agencies should support continuity of care in terms of primary healthcare services, outpatient care at a local hospital, educational services and social services.

The main purpose of a hospital is to provide healthcare services to patients. Providing appropriate care in an environment that supports and responds to each patient's unique needs requires a high level of planning and coordination. Certain activities are basic to patient care, such as planning and delivering appropriate care to each patient, monitoring the patient's response to the care provided, modifying care when necessary and completing the follow-up.

These activities are carried out by various members of the multidisciplinary team including medical, nursing, pharmaceutical and therapeutic support service personnel, among others. Each provider has a clear role to play in the patient's package of care services which is determined by each team member's particular skills, knowledge and experience. Credentials, registration, laws, regulations and hospital policies or job descriptions determine that role. Some care activities may be carried out by the patient, the family or other caregivers, who then also form part of the multidisciplinary team.

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

Continuity of care:
From entering the hospital through to discharge or transfer, the patient may encounter several departments, services and healthcare providers. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the hospital. Transfers to and from specialised units, such as critical care and the operating theatre, must be in accordance with criteria that determine the appropriateness of such transfers.
Processes for continuity and coordination of care among physicians, nurses and other healthcare providers must be implemented in and between all services. These processes should be designed collaboratively and implemented by the leaders of the various settings and services to ensure coordination of care.

Standards

19.1 Facilities and Equipment

19.1.1 *Adequate resources are available for the provision of safe care to patients in the department.*

Standard Intent

In order to provide safe patient care, each unit requires adequate resources. The physical facilities required include adequate office accommodation for personnel, sluice rooms which are hygienically clean at all times, treatment and dressing rooms and adequate storage space for clean linen. Cleaning equipment should be safely stored in a room or cupboard used for this purpose only. There should be adequate ablution facilities for the number of patients in the unit, as determined by Namibian legislation. There should be adequate lighting and ventilation.
Emergency call systems which are connected to the emergency power supply in ablution facilities and consulting rooms should be considered.
Where there is no piped oxygen and vacuum supply, there must be mobile oxygen cylinders and vacuum pumps.
All necessary fittings for oxygen and suction must be in place and working satisfactorily.

Criteria

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

19.1.1.2 Facilities allow privacy when providing personal information or undergoing examination or procedures.

19.1.1.3 Electricity and water are available in accordance with the hospital's arrangements.

19.1.1.4 There is a waiting area for patients and families.

19.1.1.5 There is adequate seating in the waiting area.

19.1.1.6 Wheelchair-accessible toilets are available.

19.1.1.7 There is access to a functioning telephone facility for use by the public.

19.1.2 . *Clinical areas within the outpatient department are adequate to meet the needs of patients.*

Standard Intent
In situations of limited resources most outpatient departments will not be located in a modern, purpose-built facility. However, the clinical areas may be arranged in a way that assists the management of most patients.
Every patient care area must have access to resuscitation equipment within one minute of any patient collapsing that includes at least

a) An ECG monitor
b) A CPR board (if required)
c) Suction apparatus(electrical and/or alternative) plus range of soft and hard suction catheters
d) d) A bag-mask manual ventilator
e) Range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) Introducer/stylet for endotracheal intubation
g) Syringe to inflate endotracheal tube cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
k) Drugs for cardiac arrest, coma, fits and states of shock (including paediatric doses)

l) A defibrillator or automated external defibrillator (AED) with adult paddles/pads (and infant paddles/pads where applicable) within three minutes of any patient collapsing

Criteria

19.1.2.1 There is a mechanism for the summoning of medical help in an emergency.

19.1.2.2 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

19.1.2.3 Oxygen and vacuum supplies meet patient care needs.

19.1.2.4 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

19.1.2.5 Diagnostic and vital sign monitoring equipment is available as per hospital policy.

19.1.2.6 There is adequate storage space to enable rapid retrieval and removal of equipment when needed.

19.1.2.7 There is evidence that equipment is maintained in accordance with the policies of the hospital.

19.1.2.8 There is access to inpatient facilities consistent with the level of care.

19.2 Service Management

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

Standard Intent

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

Criteria

19.2.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

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

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

19.2.1.5 During the hours of operation there is an adequate number of qualified professionals available to provide continuous cover to all sections at all times.

19.2.1.6 Medical cover is reflected on a roster and each practitioner on the roster is contactable by telephone, pager or other two-way communication method.

19.2.1.7 Arrangements are in place to ensure that specialist consultation services are available.

19.2.1.8 Mechanisms for contacting medical practitioners who treat private patients in the hospital are known to personnel.

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

Standard Intent

Clinical practice guidelines provide a means for improving quality and assist practitioners in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions, as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged.

Guidelines are found in the literature under many names including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by clinical leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once implemented, guidelines must be reviewed on a regular basis to ensure their continued relevance.

Criteria

19.2.2.1 Evidence-based clinical practice guidelines, relevant to the patients and services of the hospital, are available to guide patient care processes.

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

19.2.2.3 Guidelines are reviewed and adapted on a regular basis.

19.3 Assessment of Patients

19.3.1 *There is a system to ensure that patients are seen within the shortest possible time.*

Standard Intent

Patients have the right to be attended to within the shortest possible time. There should be an appointment system in operation and patients who are waiting are advised of any delays that may be experienced in receiving attention. The waiting times are monitored as part of the hospital's quality management and improvement programme. Patients requiring urgent care are identified and attended to immediately.

Criteria

19.3.1.1 There is a screening process to separate those patients requiring emergency care from those requiring only outpatient services.

19.3.1.2 There is a process of registration for outpatient care and treatment.

19.3.1.3 The register contains at least the patient's name, patient specific identification number, age, gender, date and time of attendance, treatment, procedures, referral or death.

19.3.1.4 There is an appointment system for patients.

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

19.3.1.6 Waiting times are monitored as part of the hospital's quality management and improvement programme.

19.3.2 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent
When a patient enters an outpatient department, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided. The hospital should document the scope and content of assessments to be performed by each clinical discipline within their scope of practice and applicable Namibian laws and regulations. These findings should be used throughout the care process to evaluate patient progress and provide information regarding the need for reassessment. It is essential that assessments are well documented and can be easily retrieved from the patient's record.
The hospital should determine the time frame for completing assessments. This may vary in different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the hospital

Criteria

19.3.2.1 The hospital implements policies and procedures for assessing patients on admission and during ongoing care

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

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

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

19.4 Diagnostic Services

19.4.1 *Diagnostic imaging services are available to meet patient needs.*

Standard Intent
The hospital leaders must ensure that appropriate diagnostic imaging facilities are available, that there are radiation safety programmes in place and that individuals with adequate training, skills, orientation and experience are available to undertake diagnostic imaging procedures and interpret the results.

The diagnostic imaging service must allow for immediate decision-making by practitioners through the provision of emergency services and the provision of emergency reports, as necessary.

Criteria

19.4.1.1 Adequate and convenient diagnostic imaging services are available during hours of operation.

19.4.1.2 Established waiting times for diagnostic imaging studies to be done according to triage status are monitored.

19.4.1.3 Established waiting times for diagnostic images to be available are monitored.

19.4.1.4 Where X-rays are initially interpreted by emergency unit medical personnel, there is a system for review by appropriately qualified diagnostic imaging personnel, when required.

19.4.2 *The outpatient department is adequately supported by clinical laboratory services.*

Standard Intent
Laboratory services, including those required for emergencies, may be provided within the hospital, by agreement with another hospital, or both if outside sources are convenient for the patient to access. Whatever the arrangement, it is expected that laboratory services will be available continuously on site or in close proximity to the outpatient department.

Point of care or bedside tests are performed within the outpatient department by non-laboratory personnel who give rapid results. They are particularly important where laboratory facilities are not available on the premises, as transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the outpatient department. Determination of blood glucose, either finger-prick haemoglobin or haematocrit testing, and urine testing are considered essential for an outpatient department. Centres in areas where malaria is endemic, or where tourists are frequently seen, should also have rapid, antigen-based tests for the diagnosis of Falciparum malaria. Training and quality control are required for all point-of-care tests.

Criteria

19.4.2.1 Laboratory services are available during hours of operation.

19.4.2.2 Established waiting times for laboratory tests to be done according to triage status are monitored.

19.4.2.3 Established waiting times for laboratory results to be available are monitored.

19.5 Patient Care

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

Standard Intent
The coordination of patient care depends on the exchange of information between members of the multidisciplinary team. This can be through verbal, written or electronic means according to hospital policy. Clinical leaders should use techniques to improve integration and coordination of care for their patients, e.g. team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers, etc. The process for working together will be simple and informal when the patient's needs are not complex.

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

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

Criteria

19.5.1.1 The patient's clinical records are completed according to guidelines determined by the hospital.

19.5.1.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

19.5.1.3 Information exchanged includes a summary of the initial assessment, subsequent care provided and the results of diagnostic tests.

19.5.1.4 Information exchanged includes the patient's progress.

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

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

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

19.5.1.8 Patient handover between healthcare professionals is standardised according to hospital policy.

19.5.2 *Adequate information is provided when obtaining informed consent from patients or their legal representatives*

Standard Intent

Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.

The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

- Discussion of the patient's diagnosis and why the procedure is advised
- The expected benefits of the procedure
- The likelihood of success of the procedure
- A thorough explanation of the proposed procedure
- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure
- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent - How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g. delirium, learning difficulties, etc.) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.
The leaders must agree and implement a process for the documentation of verbal consent. Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.
Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements. Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure.

Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. Where permissible according to country-specific legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant national legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

19.5.2.1 There is a documented process for obtaining or confirming informed consent.

19.5.2.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

19.5.2.3 Verbal consent is obtained and recorded according to hospital policy.

19.5.3 *Minor invasive procedures performed in the outpatient department are controlled by policy.*

Standard Intent
Patients attending the outpatient department may require invasive procedures such as biopsies, aspirations, etc. Policies and procedures should define who is permitted to perform these procedures, ensure that invasive procedures are performed based on clinical need and ensure sterility of the procedure.

Persons performing invasive procedures must be appropriately trained. Adverse events resulting from invasive procedures must be documented.

Criteria

19.5.3.1 Policies and procedures govern invasive procedures performed in the outpatient department.

19.5.3.2 Protocols guide medication use for sedation, pain and anaesthesia.

19.5.3.3 Protocols address appropriate monitoring during and after the procedure.

19.5.3.4 The procedure and the name of the person performing the procedure are recorded in the patient's record.

19.5.3.5 Unsuccessful or complicated procedures are recorded.

19.5.4 *The hospital implements processes to support the patient in managing pain.*

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

To ensure that this right is implemented, the hospital must develop processes to:

- Identify patients with pain during the initial assessment and subsequent reassessments
- Communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in the assessment and management of pain

Criteria

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

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

19.5.4.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

19.5.4.5 The hospital has processes to educate health professionals in assessing and managing pain.

19.6 Medication Management

19.6.1 *Medication is ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent
Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards.
Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian legal requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction.

"Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary. Doors, hinges and seals must all be functional.

Criteria

19.6.1.1 Medication is ordered according to hospital policy.

19.6.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

19.6.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

19.6.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

19.6.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

19.6.1.7 Medication is stored in a clean environment.

19.6.1.8 A dedicated refrigerator is available for medication requiring storage at low temperatures.

19.6.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

19.6.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

19.6.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

19.6.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

Standard Intent

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

Each hospital must identify those individuals permitted prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders are issued and documented according to hospital policy.

The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters, etc.
Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility is documented.
The patient, medical practitioner, nurse and other care providers should work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and to identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses, and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant.
The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed.
In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system should focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

19.6.2.1 Policies and procedures that guide the safe prescribing, dispensing and administration of medication are implemented.

19.6.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

19.6.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

19.6.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

19.6.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

19.6.2.6 There is evidence that patients are identified before medication is administered. CRITICAL

19.6.2.7 Medication is checked against the original prescriptions and administered as prescribed.

19.6.2.8 The medication prescribed for and administered to each patient is recorded.

19.6.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

19.6.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

19.6.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

19.7 Patient and Family Education

19.7.1 *Each patient receives relevant education, which is documented in his or her record.*

Standard Intent

The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations. Personnel involved in patient, family and caregiver education must collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective.

Education should be focused on the specific knowledge and skills that the patient, family members and caregivers will need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.

It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing admission rather than receiving care as an outpatient.

Information relating to the planning and delivery of education must be recorded in a consistent location in the patient record and follow a standardised format. Community organisations that support health promotion and disease prevention education should be identified and when possible ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

19.7.1.1 Patients and families indicate that they have received health education appropriate to their condition.

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

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

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

19.8 Continuity of Care

19.8.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent

As patients move through a hospital from admission to discharge or transfer, several departments and services and many different healthcare providers may be involved in providing care. Without

coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks. The hospital must document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

19.8.1.1 Established criteria or policies that determine the appropriateness of transfers within the hospital are implemented.

19.8.1.2 Individuals responsible for the patient's care and its coordination are identified for all phases.

19.8.1.3 Continuity and coordination are evident throughout all phases of patient care.

19.8.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

19.8.2 *There is a process for admitting patients to inpatient facilities.*

Standard Intent

The time that patients spend waiting for transfer to inpatient facilities should be minimised. Not only is this in the interest of patients' comfort and definitive management, but long holding times have a significant impact on the functioning of the outpatient department, using space, resources and nursing time.

Admission delays are often the result of system failures and processes should be designed to deal with this. Certain strategies may be implemented to manage inpatient beds more efficiently, such as more frequent consultant ward rounds and a so-called "escalation policy" can be developed in advance in collaboration with inpatient personnel to address periods of particular overcrowding.

Criteria

19.8.2.1 There is a process known to personnel, for admitting patients to the hospital.

19.8.2.2 The unit which accepts the patient for admission is noted in the patient record.

19.8.2.3 The time that the patient is accepted to the inpatient unit and the time the patient is transferred are documented in the patient record.

19.8.2.4 Holding times in the unit while awaiting transfer are monitored.

19.8.2.5 Policies and procedures that address the management of patients when bed space is not available in the desired service or unit or elsewhere in the hospital are implemented.

19.8.3 *There is a process known to personnel to refer patients for specialised consultation/investigations and/or treatment at other healthcare organisations.*

Standard Intent

Medical practitioners may need to refer patients to other healthcare facilities for a secondary consultation to confirm an opinion, to request more extensive diagnostic evaluations than may be available locally, or to have patients receive specialised treatment that the referring hospital may be unable to provide. The hospital must clearly describe the referral process, especially where patients are sent to another healthcare organisation for specialist consultation or special investigations and then return to the original hospital.

Criteria

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

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

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

19.8.4 *There is a process to transfer patients to another healthcare organisation to meet their continuing needs.*

Standard Intent

Transfer may be for specialised consultation at another healthcare organisation, for treatment, urgent services or for less intensive services such as sub-acute care or long-term rehabilitation. To ensure continuity of care, adequate information must accompany the patient.

Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer. The process for transferring the patient must consider transportation needs as well as clinical needs.

Appropriate information should accompany the patient, including at least:

- The reason for transfer
- Any special conditions related to transfer
- The condition of the patient before transfer
- Any interventions provided by the referring hospital

Criteria

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

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

19.8.4.3 The process for transferring the patient considers transportation needs.

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

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

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

19.8.4.7 The healthcare organisation agreeing to receive the patient is noted in the patient's record.

19.8.5 *There is an organised process to discharge patients who no longer require treatment or follow-up care at the hospital.*

Standard Intent

Healthcare providers should begin to plan for the patients' continuing needs as early in the care process as possible. Instructions for discharge and follow-up care at another healthcare organisation, e.g. primary health care clinic, must be clear and provided in writing.
Where patient-held records are not used, the discharge note is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.
At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The discharge summary must contain the following content as a minimum:

a) The diagnosis of main and significant illnesses
b) The results of investigations that will influence further management
c) All procedures performed
d) The patient's condition at discharge
e) Discharge medication
f) Follow-up arrangements where appropriate, including emergency review

Criteria

19.8.5.1 There is a documented process to discharge patients.

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

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

19.8.5.4 A discharge summary, which includes (a)-(f) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

19.8.5.5 Each record contains a copy of the discharge summary.

19.9 Quality Improvement

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

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7).
It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central/coordinating quality improvement structures.
Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

- Patient assessment
- The use of antibiotics and other medication and medication errors
- The availability, contents and use of patient records
- Waiting times
- Patient and family expectations and satisfaction The following will be evaluated:

- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC.
Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

19.9.1.1 There are formalised quality improvement processes for the service that have been developed and agreed by the personnel of the department or service.

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

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

19.9.1.4 A documentation audit system is in place.

19.10 Patient Rights

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

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

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

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

19.10.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

19.11 Prevention and Control of Infection

19.11.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

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

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

19.11.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

19.11.1.7 Infection control processes include safe injection practices, including single-use injection devices.

19.11.1.8 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

19.12 Risk Management

19.12.1 *The department/service implements risk management processes.*

Standard Intent

This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

19.12.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

19.12.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

19.12.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

19.12.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

19.12.1.5 Fire safety measures are implemented.

19.12.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

20 Combined Outpatient and Emergency Care

OVERVIEW OF COMBINED OUTPATIENT AND EMERGENCY CARE

This service element is intended to be used in hospitals that do not have separate outpatient and emergency departments, as is frequently the arrangement in smaller hospitals. Emergency cases should be managed in such a way as to cause minimal disruption to the provision of outpatient care.

Outpatient care is care and treatment provided on an outpatient basis and does not include a stay of longer than 24 hours. Outpatient care may be an integral part of the continuum of care provided before or after a period of hospitalisation, or may be provided to a patient who is referred from a community-based organisation. In some hospitals, outpatient care may be considered an independent, comprehensive service encompassing all outpatient visits.

Emergency care is provided at many different levels and clearly the expectations in terms of expertise and equipment are different. These standards are deliberately not prescriptive in regard to the physical facilities. Although optimisation of the physical environment is an important goal, excellent care can be provided with limited resources.

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

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

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

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

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

Processes for continuity and coordination of care among physicians, nurses and other healthcare providers, must be implemented in and between all services. Leaders of various settings and services should work together to design and implement the required processes, thus ensuring coordination of care.

20.1 Facilities and Equipment

20.1.1 *Adequate resources are available for the provision of safe care to patients in the unit.*

Standard Intent

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

adequate toilet and bathing facilities for the number of patients in the ward, as determined by Namibian legislation.
There should be adequate lighting and ventilation.
Emergency call systems are available in consulting rooms and in bathrooms and toilets and are connected to the emergency power supply.
Where there is no piped oxygen and vacuum supply, there must be mobile oxygen cylinders and vacuum pumps. All necessary fittings for oxygen and suction must be in place and working satisfactorily.
Each room must be provided with a socket outlet that is connected to the emergency power supply.

Criteria

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

20.1.1.2 Facilities allow privacy when providing personal information, or undergoing examination or procedures.

20.1.1.3 Electricity and water are available in accordance with the hospital's arrangements.

20.1.1.4 There is a waiting area for patients and families.

20.1.1.5 There is adequate seating in the waiting area.

20.1.1.6 Wheelchair accessible toilets are available.

20.1.1.7 Quiet and private areas are available for waiting relatives and grieving or otherwise distressed relatives or carers.

20.1.1.8 There is access to a functioning public telephone facility for patients, relatives and visitors.

20.1.2 *Clinical areas within the outpatient and emergency department are adequate to meet the needs of patients.*

Standard Intent
In situations of limited resources most emergency units will not be located in a modern, purpose-built facility. However, the clinical areas may be arranged in a way that assists management of the most critical patients. For instance, there should be a designated resuscitation area situated in close proximity to the ambulance entrance. The arrival of critical patients may be unpredictable, particularly in regions where patients use unofficial emergency transport and there must be an alarm system, audible in the personnel rest areas, to indicate the
arrival of a critical patient.
Major and regional units should be equipped with a decontamination area for the management of patients exposed to hazardous materials which:

- Is in close proximity to the ambulance entrance
- Provides for patient privacy
- Has a raised barrier to protect personnel
- Is spacious enough for patient and personnel
- Has good water run off such that contaminated material can be collected and isolated

Operating theatre facilities may be located on a different floor, in which case there must be a lift over-ride mechanism. Comprehensive trauma and emergency care will require inpatient care for most major cases.

Criteria

20.1.2.1 There is a designated triage area.

20.1.2.2 There is a designated resuscitation area.

20.1.2.3 There is a mechanism for summoning medical help in an emergency.

20.1.2.4 Oxygen and vacuum supplies meet patient care needs.

20.1.2.5 When patients receive oxygen from a cylinder, the cylinder pressures are monitored according to hospital policy.

20.1.2.6 There is adequate storage space to enable rapid retrieval and removal of equipment when needed.

20.1.2.7 There is evidence that equipment is maintained in accordance with the policies of the hospital.

20.1.2.8 Each patient in the emergency department has access to a nurse call system at all times.

20.1.2.9 There is a low pressure, hand-held shower suitable for the management of patients contaminated with hazardous materials.

20.1.2.10 There is access to inpatient facilities consistent with the level of care.

20.1.2.11 There is easy access to the operating theatre.

20.1.3 *Resuscitation equipment is available in accordance with the policies of the hospital.*

Standard Intent
Resuscitation equipment must be available in the unit and must be checked in accordance with the hospital's resuscitation policy. Checking must include expiry dates on medication and consumables such as airways and endotracheal tubes. Documented evidence of this checking is required.

Resuscitation trollies and defibrillators or automated external defibrillators (AED) should be available in the department in accordance with the level of services provided.

It is important to carry a range of adult and paediatric size equipment and a reasonable selection within each range. Namibian arrangements will apply.

Resuscitation equipment should include at least:

a) A defibrillator with adult paddles/pads (and infant paddles/pads where applicable)
b) An ECG monitor
c) A CPR board (if required)
d) Suction apparatus (electrical and/or alternative) plus range of soft and hard suction catheters
e) Bag-mask manual ventilators in an appropriate number to suit the size of the facility
f) A range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
g) An introducer/stylet for endotracheal intubation
h) A syringe to inflate the ETT cuff
i) Oropharyngeal tubes
j) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle

k) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
l) Drugs for cardiac arrest, coma, fits and states of shock (including paediatric doses where applicable)

Criteria

20.1.3.1 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

20.1.3.2 Recommended appliances are available for specialised resuscitations.

20.1.3.3 Diagnostic and vital sign monitoring equipment is available as per hospital policy.

20.1.4 *There is a rest area for personnel in close proximity to the clinical areas.*

Standard Intent

Rest areas for personnel should be adequately equipped to allow personnel to remain in the vicinity of the department at all times. The type of facilities provided will vary and will depend on the length of shifts undertaken and access to other refreshment facilities in close proximity to the department.

Criteria

20.1.4.1 There is an adequately equipped kitchen, with at least a kettle, toaster and microwave.

20.1.4.2 There are rest room facilities for personnel including a changing area, toilet and hand washing facilities.

20.1.4.3 Where personnel undertake 24 hour shifts, there are sleeping and shower facilities.

20.1.4.4 The rest area is equipped with a telephone or intercom system.

20.2 Patient Registers

20.2.1 *Patient registers are kept and comply with Namibian requirements and/or hospital policy.*

Standard Intent

Hospitals may be required by Namibian law and regulation to maintain registers of patients attending the emergency department and patients receiving radiological investigations. Attendance registers should include mode of arrival, time of arrival, name, date, treatment administered and information on final disposition (admission, discharge, death or transfer).

Criteria

20.2.1.1 A register is kept of patients attending the emergency department.

20.2.1.2 The register contains at least the patient's name, patient-specific identification number, age, gender, date and time of admission, treatment, procedures, discharge, referral or death.

20.2.1.3 The information in the register is used to monitor waiting periods from time of arrival to time of assessment.

20.3 Service Management

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

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

Criteria

20.3.1.1 An appropriately qualified individual has clearly defined responsibilities and accountability for all aspects of the service.

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

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

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

20.3.1.5 During the hours of operation there is an adequate number of qualified professionals available to provide continuous cover to all sections at all times.

20.3.1.6 Emergency services personnel maintain skills in advanced life support in accordance with hospital policy.

20.3.1.7 Medical cover is reflected on a roster and each practitioner on the roster is contactable by telephone, pager or other two-way communication method.

20.3.1.8 Arrangements are in place to ensure that adequate specialist consultation services are available.

20.3.1.9 Mechanisms for contacting medical practitioners who treat private patients in the hospital are known to personnel.

20.3.2 *Clinical practice guidelines are used to guide patient care and reduce unwanted variation*

Standard Intent
Clinical practice guidelines provide a means for improving quality and assist practitioners in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions, as these are the areas that represent the highest risk to patients and the hospital. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged, e.g. hepatitis E in a non-endemic area.

Guidelines are found in the literature under many names including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways, etc. Regardless of the source,

the scientific basis of guidelines should be reviewed and approved by clinical leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and hospital resources. Once adopted, guidelines must be reviewed on a regular basis to ensure their continued relevance.

Criteria

20.3.2.1 Evidence-based clinical practice guidelines relevant to the patients and services of the hospital are available to guide patient care processes.

20.3.2.2 Clinical practice guidelines include protocols for time-critical states.

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

20.3.2.4 Guidelines are reviewed and adapted on a regular basis.

20.4 Visitor Control

20.4.1 *A system of visitor control is maintained to ensure the safety of patients and personnel.*

Standard Intent

Controlling visitors' access to the unit is important, not only as a security precaution but because anxious relatives in clinical areas can impede delivery of services. Additionally, community emergencies, VIP admissions and other newsworthy events may lead to invasion by the media. Policies should be available to guide all personnel, but clerical and security personnel are particularly important in implementing visitor control.

Criteria

20.4.1.1 The hospital's policy on visitors to the emergency department is implemented.

20.4.1.2 There is a system to inform patients and family of the visitors' policy.

20.4.1.3 Areas where access is denied to persons other than personnel are clearly marked.

20.4.1.4 The discretionary powers of personnel in charge of the service relating to visitors under special circumstances are documented.

20.4.1.5 Policies regarding media invasion are implemented to guide clinical and security personnel.

20.5 Assessment of Patients

20.5.1 *The hospital has a formal triage process which uses documented guidelines to determine urgency.*

Standard Intent

This standard refers to initial triage by either a medical practitioner or registered nurse. In urgent cases, initial management will take place simultaneously with assessment. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the hospital.

It is essential that triage assessments are properly documented, legible and easily retrieved from the patient's record.

Following the triage assessment, patients should see the relevant professional within appropriate time frames established by the professional societies or hospital policy, e.g.
Red Patients: Immediate
Orange Patients: Less than 20 minutes
Yellow Patients: Less than 60 minutes
Green Patients: Less than 240 minutes

An internationally acceptable evidence-based method of patient triage must be implemented.

All personnel responsible for patient triage are trained in the triage process selected for implementation in the unit.

Criteria

20.5.1.1 The unit implements an evidence-based triage system.

20.5.1.2 All personnel responsible for patient triage have received training in the application of the triage system.

20.5.1.3 Clinical records of emergency patients include the time of arrival.

20.5.1.4 The triage category for each patient is recorded.

20.5.1.5 Clinical records of emergency patients include time of referral to medical practitioner.

20.5.1.6 Waiting times from triage categorisation to initial assessment are monitored.

20.5.2 *All patients cared for by the hospital have their healthcare needs identified through an established assessment process.*

Standard Intent

When a patient enters the emergency department, the specific information required and the procedures for obtaining and documenting it depend on the patient's needs and on the setting in which care is being provided. Assessments must be completed with due regard to privacy. This is particularly important when the patient is a victim of social or sexual violence.
The hospital should define in writing the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations.
The hospital should determine the time frame for completing assessments. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the hospital.
The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Financial factors are assessed as part of the social assessment, particularly when the patient and his/her family will be responsible for the cost of all or a portion of the care.
A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary. Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependence and victims of abuse and neglect. The assessment process should be modified in accordance with local custom.
The outcome from the patient's initial assessment results in an understanding of the patient's medical and nursing needs so that care and treatment can begin.

When the medical assessment was conducted outside the hospital, a legible copy of the findings must be placed in the patient's record. Any significant changes in the patient's condition since this assessment must be recorded. Psychiatric patients may present acutely to emergency units with conditions that cannot be managed effectively in this setting. In these instances, access to appropriate care can be expedited by means of a standing agreement developed collaboratively between the emergency unit and the nearest psychiatric unit. A formal agreement with clearly defined referral pathways can be of benefit in these situations to expedite the patient's access to appropriate services.

Criteria

20.5.2.1 The hospital implements policies and procedures for assessing patients on admission and during ongoing care.

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

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

20.5.2.4 Assessments are performed within appropriate time frames and are comprehensively documented in the patient' records according to hospital policy.

20.5.2.5 Agreements are in place with the nearest psychiatric unit to ensure appropriate, expedited care for psychiatric patients.

20.5.3 *There is a system to ensure that patients are seen within the shortest possible time.*

Standard Intent

Patients attending the outpatient department have the right to be attended to within the shortest possible time. There should be an appointment system in operation and patients who are waiting should be advised of any delays that may be experienced in receiving attention. The waiting times should be monitored as part of the hospital's quality management and improvement programme. Patients requiring urgent care must be identified and attended to immediately.

Criteria

20.5.3.1 There is a screening process to separate those patients requiring emergency care from those requiring only outpatient services.

20.5.3.2 There is a process of registration for outpatient care and treatment.

20.5.3.3 The register contains at least the patient's name, patient specific identification number, age, gender, date and time of attendance, treatment, procedures, referral or death.

20.5.3.4 There is an appointment system for patients.

20.6 Diagnostic Services

20.6.1 *Diagnostic imaging services are available to meet patient needs.*

Standard Intent

The hospital's leaders must ensure that appropriate diagnostic imaging facilities are available, that radiation safety programmes are in place and that individuals with adequate training, skills, orientation and experience are available to undertake diagnostic imaging procedures and interpret the results.

The diagnostic imaging service must allow for immediate decision-making by practitioners through the provision of emergency services and the provision of emergency reports, as necessary.

Criteria

20.6.1.1 Adequate and convenient diagnostic imaging services are available at all times.

20.6.1.2 Established waiting times for diagnostic imaging studies to be done according to triage status are monitored.

20.6.1.3 Established waiting times for diagnostic images to be available are monitored.

20.6.1.4 Where X-rays are initially interpreted by emergency unit medical personnel, there is a system for review by appropriately qualified diagnostic imaging personnel, when required.

20.6.2 *The outpatient and emergency department is adequately supported by clinical laboratory services.*

Standard Intent

Laboratory services, including those required for emergencies and after-hours services, may be provided within the hospital, by agreement with another organisation, or both if outside sources are convenient for the patient to access. Whatever the arrangement, it is expected that laboratory services will be available continuously and should be on site or in close proximity to the emergency department. Point of care or bedside tests can be performed within the outpatient department by non-laboratory personnel and give rapid results. They are particularly important where laboratory facilities are not available on the premises; transport time to external facilities can be a major factor delaying appropriate treatment or discharge from the emergency department. Determination of blood glucose, either finger-prick haemoglobin or haematocrit testing and urine testing are considered essential for an outpatient department. Centres in areas where malaria is endemic or where tourists are frequently seen should also have rapid, antigen-based tests for the diagnosis of Falciparum malaria. Training and quality control are required for all point of care tests.

The majority of urgent clinical decisions can be made based on the results of point of care testing outlined above; however, emergency departments require urgent laboratory services for the provision of specialised testing.

Criteria

20.6.2.1 Laboratory services are available at all times.

20.6.2.2 Established waiting times for laboratory tests to be done according to triage status are monitored.

20.6.2.3 Established waiting times for laboratory results to be available are monitored.

20.7 Patient Care

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

Standard Intent

The coordination of patient care depends on the exchange of information between the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means as determined by hospital policies. The policies should indicate the appropriate means of communication. Clinical leaders should use techniques to better integrate and coordinate care for their patients (for example, team-delivered care, integrated patient records, and case managers).

Policies and procedures should describe standardised handover procedures to be followed when receiving patients from or transferring patients to the ambulance service and wards, as well as when handing over to a new shift. As a minimum, handovers between shifts in the emergency department should include formal handover of patients triaged into categories requiring immediate or urgent medical attention.

Standardisation of this process reduces variability in the information exchanged, thereby reducing the likelihood that important information is omitted in the handover process. The World Health Organisation recommends the

SBAR approach (Situation, Background, Assessment, Recommendation).

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

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

Criteria

20.7.1.1 The patient's clinical records are completed according to guidelines determined by the hospital.

20.7.1.2 The patient's records are up to date to ensure the transfer of the latest information between care providers.

20.7.1.3 Information exchanged includes a summary of the initial assessment, subsequent care provided and the results of diagnostic tests.

20.7.1.4 Information exchanged includes the patient's progress.

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

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

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

20.7.1.8 Patient handover between healthcare professionals is standardised according to hospital policy.

20.7.2 *Adequate information is provided when obtaining informed consent from patients or their legal representatives*

Standard

Hospital policy must define the situations under which informed consent is required and specify the type of consent required, e.g. written or verbal consent.

The leaders must agree and implement a standardised procedure for obtaining informed consent which meets all requirements of Namibian legislation and includes:

- Discussion of the patient's diagnosis and why the procedure is advised
- The expected benefits of the procedure
- The likelihood of success of the procedure
- A thorough explanation of the proposed procedure

- The potential risks and complications of the procedure
- A discussion of viable alternative options including risks and benefits
- The potential risks of refusing the proposed procedure
- Confirmation that the patient or their legal representative has understood the information provided
- An opportunity for the patient or their legal representative to ask questions
- Comprehensive documentation of the process followed to obtain informed consent - How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (e.g. delirium, learning difficulties, etc.) or by virtue of their physical illness (e.g. comatose)
- Documentation of the signature of the patient or their legal representative for written consent
- Documentation of verbal consent in the patient record

The procedure for obtaining informed consent should acknowledge and accommodate religious, cultural and social needs of patients and their families.
The leaders must agree and implement a process for the documentation of verbal consent. Where written consent is required, it can be useful to include the steps in the process in the consent form with space allocated for signature of the patient and the personnel member providing the information to confirm that the step has been completed satisfactorily.
Personnel responsible for obtaining informed consent must receive training on the agreed policies and procedures relating to informed consent to ensure that they are fully aware of hospital requirements. Consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications and alternatives. Ideally, the person who will perform the procedure should be the one to obtain consent for the procedure.

Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure. Where permissible according to Namibian legislation, hospital personnel who can consent on behalf of patients unable to give independent consent should be identified. This will require a detailed policy and procedure which should reflect the requirements set out in the relevant Namibian legislation. A copy of this legislation should be available to be read in conjunction with the policy.

Criteria

20.7.2.1 There is a documented process for obtaining or confirming informed consent.

20.7.2.2 Consent forms or the form confirming consent are completed comprehensively and available in patient records.

20.7.2.3 Verbal consent is obtained and recorded according to hospital policy.

20.7.3 *Invasive procedures and minor operations performed in the outpatient and emergency department are controlled by policy.*

Standard Intent

Patients attending the emergency unit may require invasive procedures such as central venous cannulation or tube thoracotomy. Policies and procedures must define who should perform these procedures, for what indications and under what conditions, ensure that they are performed based on clinical need and meet infection control requirements.
Persons performing invasive procedures must be appropriately trained.
Adverse events resulting from invasive procedures should be documented and investigated and appropriate steps taken to prevent recurrence or minimise harm in the event of a recurrence.

Criteria

20.7.3.1 Policies and procedures govern invasive procedures performed in the outpatient and emergency department.

20.7.3.2 Protocols guide medication use for sedation, pain and anaesthesia.

20.7.3.3 Protocols address appropriate monitoring during and after the procedure.

20.7.3.4 The procedure and the name of the person performing the procedure are recorded in the patient's record.

20.7.3.5 Unsuccessful or complicated procedures are recorded.

20.7.4 *Post-operative assessments are documented.*

Standard Intent
A patient's post-surgical care is related to the findings and the surgical procedure. The surgical report must be available within a time frame needed to provide post-surgical care to the patient.
Post-operative monitoring must be appropriate to the patient's condition and the procedure performed. Results of monitoring influence intra- and post-operative decisions such as return to surgery, transfer to another level of care and the need for further investigations or discharge.

Criteria

20.7.4.1 A post-operative diagnosis is documented.

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

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

20.7.5 *The hospital implements processes to support the patient in managing pain.*

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

The hospital has processes to:

- Identify patients with pain during initial assessment and re-assessment
- Communicate with and provide education for patients and families about pain management in the context of their personal, cultural and religious beliefs
- Educate healthcare providers in pain assessment and management

Criteria

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

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

20.7.5.3 There is evidence that the effectiveness of pain and symptom management is monitored.

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

20.7.5.5 The hospital has processes to educate health professionals in assessing and managing pain.

20.7.6 *There is access to emergency blood and blood products in accordance with hospital policy.*

Standard Intent
Facilities should have emergency blood on site with access to banked blood within one hour. The type and amount of emergency blood and blood products to be kept on site will be determined by hospital policy. Emergency blood may in some facilities not be kept in the emergency care unit, but in another department. Arrangements for access at all times must form part of the hospital policy.

Criteria

20.7.6.1 Emergency blood is available at all times.

20.7.6.2 There is a designated refrigerator for emergency blood and blood products.

20.7.6.3 The temperature of the refrigerator is monitored and recorded according to hospital policy.

20.7.6.4 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

20.7.6.5 Banked emergency blood is subject to stock control, which includes the replacement of stock before its expiry date.

20.8 Medication Management

20.8.1 *Medications are ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent
Hospital policy on the ordering and storage of medication must be followed in each patient care area which stores medication for administration to patients under their care. Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medication. The hospital must identify any additional individuals permitted to order medication in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulation and professional practice standards.

Medication must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary. Scheduled (controlled) drugs/narcotics/barbiturates and other dangerous drugs must be stored according to Namibian legal requirements. As a minimum, these drugs must be stored in a locked cupboard or container of substantial construction. "Substantial" construction is interpreted to be a cupboard/container that is mounted to the wall or fixed to the floor. Mostly these are steel cabinets, but solid wooden cupboards are also acceptable. There must be a registry, log or other system to monitor and account for controlled substances, which must be completed at the same time that medication is received, administered or returned.

Refrigeration facilities must be provided for safe storage of certain medication. There must be a process to ensure that thermolabile medication has been stored and transported at the correct temperature throughout the life of the medication. Refrigerators must be defrosted when necessary.
Doors, hinges and seals must all be functional.

Criteria

20.8.1.1 Medication is ordered according to hospital policy.

20.8.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines (e.g. security, temperature control).

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

20.8.1.4 Medication identified for special control by legislation or hospital policy is stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

20.8.1.5 Medication identified for special control by legislation or hospital policy is accurately accounted for.

20.8.1.6 Medication is securely and legibly labelled with relevant information as required by legislation and hospital policy.

20.8.1.7 Medication is stored in a clean environment.

20.8.1.8 A dedicated refrigerator is available for medication requiring storage at low temperatures.

20.8.1.9 The temperature of the refrigerator is monitored and recorded according to hospital policy.

20.8.1.10 Appropriate action is taken and recorded when the temperature of the refrigerator is outside the recommended range.

20.8.1.11 Expiry dates (including those of emergency drugs) are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

20.8.2 *Medication use throughout the hospital complies with applicable laws and regulations.*

Standard Intent
Medication management is not only the responsibility of the pharmaceutical service but also of managers and clinical care providers. Medical, nursing, pharmacy and administrative personnel should participate in a collaborative process to develop and monitor policies and procedures. Each hospital must identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by Namibian law, registration or regulations to prescribe medication. The hospital must identify any additional individuals permitted to prescribe medication in emergency situations. Prescription of medication and verbal medication orders must be issued and documented according to hospital policy.

The safe administration of medication requires a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that

the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled to indicate the site of placement, e.g. arterial, epidural and intrathecal catheters,etc. Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers must work together to monitor patients on medication. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically insignificant. The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed.

In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of errors that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of the error happening again. Personnel training, either in existing or adapted medication administration processes, can be beneficial in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

20.8.2.1 Policies and procedures that guide the safe prescribing, dispensing and administration of medications are implemented.

20.8.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

20.8.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medication.

20.8.2.4 On admission, all current medication taken by the patient is documented in the patient record, including herbal and over-the-counter medication.

20.8.2.5 Verbal and telephonic medication prescriptions are documented according to hospital policy.

20.8.2.6 There is evidence that patients are identified before medication is administered.

20.8.2.7 Medication is checked against the original prescriptions and administered as prescribed.

20.8.2.8 The medication prescribed for and administered to each patient is recorded.

20.8.2.9 Healthcare professionals monitor medication effects on patients collaboratively.

20.8.2.10 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

20.8.2.11 Medication errors are reported through a process and within a time frame defined by the hospital.

20.9 Patient and family education

20.9.1 *Each patient receives relevant education, which is written in his or her record.*

Standard Intent
The hospital must select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations. Personnel involved in patient, family and caregiver education must collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective. Education must be focused on the specific knowledge and skills that the patient, family members and caregivers will need to make care decisions, participate in care and continue care at home, e.g. changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.
It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to be admitted rather than receiving care as an outpatient.
Information relating to the planning and delivery of education must be recorded in a consistent location in the patient record and follow a standardised format. Community organisations that support health promotion and disease prevention education should be identified and when possible ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

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

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

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

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

20.10 Continuity of care

20.10.1 *The hospital designs and implements processes to provide continuity of patient care services within the hospital and coordination among health professionals.*

Standard Intent
As patients move through the hospital from admission to discharge or transfer, several departments and services and many different healthcare providers may be involved in providing care. Without coordination and effective transfer of information and responsibilities, errors of omission and commission may occur, exposing the patient to avoidable risks. The hospital must document and implement procedures to minimise the likelihood of these errors occurring.

Criteria

20.10.1.1 Established criteria or policies that determine the appropriateness of transfers within the hospital are implemented.

20.10.1.2 Individuals responsible for the patient's care and its coordination are identified for all phases of patient care.

20.10.1.3 Continuity and coordination are evident throughout all phases of patient care.

20.10.1.4 When a patient is transferred within the hospital, they are accompanied by their patient record.

20.10.2 *The hospital implements policies for the management of patients requiring short-term observation and care.*

Standard Intent

Where emergency departments have short-stay facilities, also known as admission/overnight or observation facilities, they should be controlled by policies which address:

- Which cases may appropriately be observed in the emergency department rather than in inpatient facilities
- Who is responsible for the patient
- Timing of medical reassessment
- Length of stay

The facilities should be adequate for safe medical care and medical records should clearly state the parameters under observation and actions to be taken should these parameters change.

Criteria

20.10.2.1 Policies and procedures that address the holding of patients for observation are implemented.

20.10.2.2 The hospital has established appropriate time frames which limit holding time in the emergency unit.

20.10.2.3 Patients under observation are reassessed at appropriate intervals to determine their response to care and treatment and this is documented in the record.

20.10.2.4 Any significant changes in the patient's condition are noted in the patient's record and acted upon appropriately.

20.10.2.5 Any patient care meetings or other discussions are noted in the patient's record.

20.10.2.6 Holding times are monitored and audited.

20.10.3 *There is a process for admitting patients to inpatient facilities.*

Standard Intent

The time that patients spend waiting for transfer to inpatient facilities should be minimised. Not only is this in the interest of patients' comfort and definitive management, but long holding times have a significant impact on the functioning of the emergency department, using space, resources and nursing time. Admission delays are often the result of system failures and processes should be designed to deal with this. The emergency department can become congested when there is a lack of inpatient beds. Certain strategies may be implemented to manage inpatient beds more efficiently, such as more frequent consultant ward rounds and a so-called "escalation policy" to address periods of particular overcrowding can be developed in advance with inpatient personnel.

Criteria

20.10.3.1 There is a process known to personnel for admitting patients to the hospital.

20.10.3.2 The unit which accepts the patient for admission is noted in the patient record.

20.10.3.3 The time that the patient is accepted to the inpatient unit and the time the patient is transferred are documented in the patient record.

20.10.3.4 Holding times in the unit while awaiting transfer are monitored.

20.10.3.5 Policies and procedures that address the management of patients when bed space is not available in the desired service or unit or elsewhere in the hospital are implemented.

20.10.4 *There is a process known to personnel to refer patients for specialised consultation/investigations at other healthcare facilities.*

Standard Intent

Medical practitioners may need to refer patients to other facilities for a secondary consultation to confirm an opinion, to access more extensive diagnostic evaluations than may be available locally, or to access specialised treatment that the referring hospital may be unable to provide.

This standard refers to the process by which a patient is referred to another healthcare organisation only to access services not offered by the referring hospital and then returns to the referring hospital to receive ongoing care, either as part of their care as an inpatient (in which case they will return to the ward following their review at the referral hospital) or while under the care of the outpatient department. Hospital policy must clearly describe this referral process.

Criteria

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

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

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

20.10.5 *There is a process to transfer patients to another healthcare organisation to meet their continuing needs.*

Standard Intent

Transfer may be for specialised consultation or investigation at another healthcare organisation for treatment, urgent services, or for less intensive services such as sub-acute care or long-term rehabilitation. To ensure continuity of care, adequate information must accompany the patient.

Transfer may be an uncomplicated process with the patient alert and talking, or may involve continuous nursing or medical supervision. The qualifications of the individual accompanying the patient must be appropriate to the level of care required during transfer. The process for transferring the patient must consider transportation needs. Patients may require transfer to another healthcare organisation, either to address their ongoing needs more appropriately, or because of patient or family choice or financial concerns. However, all patients who require resuscitation and stabilisation must receive such care prior to transfer.

In a well-organised system, the capabilities of individual hospitals will be catalogued and coordinated, so that arrangements will already exist with units to which the hospital frequently refers. When transfer criteria and processes are formally agreed in advance, patients are more likely to receive appropriate emergency care when their needs exceed the capabilities of the hospital.

Appropriate information should accompany the patient, including at least:
- The reason for transfer
- Any special conditions related to transfer
- The condition of the patient before transfer
- Any interventions provided by the referring hospital

Criteria

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

20.10.5.2 Patients are stabilised according to appropriate clinical guidelines prior to transfer.

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

20.10.5.4 The process for transferring the patient considers transportation needs.

20.10.5.5 A policy that requires the responsible clinician to communicate the level of care required to Emergency Medical (ambulance) services is implemented.

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

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

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

20.10.5.9 The healthcare organisation agreeing to receive the patient is noted in the patient's record.

20.10.6 *There is an organised process to discharge patients who are being treated and released.*

Standard Intent

Care planning should include arrangements to meet the patient's continuing needs after discharge as early in the care process as possible. Instructions for discharge and follow-up visits must be clear and provided in writing. Where patient-held records are not used, the discharge summary is one of the most important documents for ensuring continuity of care and facilitating correct management at subsequent visits. Information provided by the hospital may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

At discharge, patients should be alerted to symptoms and signs related to their diagnosis which require urgent medical attention and how to access healthcare services should they develop such symptoms or signs. This process is referred to as "safety-netting".

The discharge summary must contain the following content as a minimum: a) The reason for admission
b) The diagnosis of main and significant illnesses
c) The results of investigations that will influence further management
d) All procedures performed
e) The patient's condition at discharge
f) Discharge medications

g) Follow-up arrangements where appropriate, including emergency review

Criteria

20.10.6.1 There is a documented process to discharge patients.

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

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

20.10.6.4 A discharge summary, which includes (a)-(g) in the standard intent above as a minimum, is written by the medical practitioner when each patient is discharged.

20.10.6.5 Each record contains a copy of the discharge summary.

20.11 Ambulance services

20.11.1 *Where the hospital provides an ambulance service, this service is delivered in line with relevant Namibian laws and regulations.*

Standard Intent

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

Criteria

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

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

20.11.1.3 The hospital designs and implements processes to provide coordination of services among other hospitals and agencies in the community.

20.11.1.4 The individuals who provide patient care in the ambulance service have the required training and experience.

20.11.1.5 The individuals responsible for management of the ambulance service develop a list of the equipment required for each ambulance in collaboration with other relevant services.

20.11.1.6 The hospital plans and implements processes for inspecting, testing and maintaining equipment and supplies.

20.11.1.7 The hospital maintains its ambulance vehicles to reduce risk and promote safety.

20.11.1.8 Medical transport/ambulance vehicles are cleaned in accordance with hospital policy.

20.12 Quality improvement

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

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7).
It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality management structures. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.

- Quality monitoring could include:
- Patient assessment
- Resuscitation interventions
- Surgical procedures carried out
- The use of antibiotics and other medications and medication errors
- The use of anaesthesia
- The use of blood and blood products
- Waiting times
- Patient and family expectations and satisfaction The following will be evaluated:
- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC.
Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

Criteria

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

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

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

20.12.1.4 A documentation audit system is in place.

20.13 Patient rights

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

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4).

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

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

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

20.13.1.3 The personnel respect the right of patients and families to receive treatment and the right to refuse treatment.

20.14 Prevention and control of infection

20.14.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

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

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

20.14.1.3 Personnel are trained in correct hand washing procedures.

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

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

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

20.14.1.7 Infection control processes include safe injection practices, including single-use injection devices.

20.14.1.8 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

20.15 Risk management

20.15.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

20.15.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

20.15.1.2 A system for monitoring near misses/adverse events/sentinel events is implemented, which includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

20.15.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

20.15.1.4 Security measures are implemented to ensure the safety of patients, personnel and visitors.

20.15.1.5 Fire safety measures are implemented.

20.15.1.6 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

21 Occupational Health Service

OVERVIEW OF OCCUPATIONAL HEALTH SERVICE

This Service Element will be applicable only where a comprehensive Occupational Health Service is provided by the hospital. Within this Service Element, the term "personnel" is used to refer to those providing the Occupational Health Service at the hospital, whereas "employees" refers to the employees accessing the Occupational Health Service, i.e. the employees of the hospital or organisation.

The functions relating to Occupational Health Services are diverse and for the purposes of this document will be categorised according to the requirements necessary to provide a comprehensive service.

Occupational Health Services need to take into consideration the health risks specific to the work environment of employees. With regard to work-related risks, the occupational health personnel should work closely with the risk management committees where present, to ensure that risks are identified, assessed, controlled and monitored and that control measures implemented are monitored for effectiveness.

Health education specific to the risks of the work environment should be offered routinely to ensure that employees have sufficient knowledge to mitigate the risk of their work environment to themselves and others. This aspect of the service is especially important as occupational health personnel are ideally placed, trained and tasked to offer such advice.

The Occupational Health Service should encourage an organisational culture that strives for continual improvement in accident rates and aims to eliminate accidents and risk to health.

Standards

21.1 Organisation and Coordination

21.1.1 *The service is organised to provide a safe and effective service and is coordinated with other relevant services.*

Criteria

21.1.1.1 The lines of communication between the hospital, referral facilities and community services are clearly defined.

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

21.1.1.3 An on-call roster is available for after-hours, weekend and holiday emergency cover (e.g. for infectious diseases).

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

21.1.1.5 Laboratory services are available to meet the needs of employees.

21.1.1.6 A register is kept of all laboratory specimens sent and results received.

21.1.1.7 Radiology services are available to meet the needs of employees.

21.2 Facilities and Equipment

21.2.1 *Required furniture and equipment are available and functional.*

Standard Intent
In order to provide safe employee care, each unit requires adequate resources. An assessment should be made as to whether the hospital has the required furniture and equipment. Departments should complete an inventory of their furniture and equipment based on the standard lists and report the percentage of total items they have in stock relative to the total recommended. Management must ensure that resources are adequate to meet statutory requirements and the needs of employees.
The physical facilities required include adequate office accommodation for personnel. Occupational health managers should keep hospital managers informed of facilities which are inadequate, additional equipment requirements and the current state of facilities and equipment.

Criteria

21.2.1.1 Occupational health offices are clearly sign-posted.

21.2.1.2 There is a mechanism to prevent unauthorised individuals from entering the offices.

21.2.1.3 There is a reception area for employees.

21.2.1.4 There is adequate office space for administrative activities.

21.2.1.5 There is privacy for interviewing employees.

21.2.1.6 Lockable facilities for storing personal clothing and property are provided.

21.2.1.7 Ablution facilities are provided.

21.2.1.8 Transport is available for occupational health personnel to perform their functions.

21.2.1.9 Facilities and equipment are maintained to provide clean and safe working conditions, which comply with relevant legislation.

21.2.1.10 Records of equipment maintenance are available.

21.3 Management of the Occupational Health Service

21.3.1 *The Occupational Health Service is managed to provide the personnel and resources required for an effective service.*

Criteria

21.3.1.1 A designated person is responsible and accountable for the management of the Occupational Health Service.

21.3.1.2 There is an adequate number of personnel to provide for the needs of the Occupational Health Service.

21.3.1.3 Occupational health personnel have the necessary and appropriate training, credentials and skills to carry out their responsibilities.

21.3.1.4 Occupational health personnel participate in continuing medical education in occupational health.

21.3.1.5 Occupational health personnel have appropriate access to a physician with expertise and credentials in occupational health care.

21.3.2 *The mission statement and overall policy of the Occupational Health Service reflect current international best practice.*

Standard Intent
The Occupational Health Service should have a mission statement that reflects the needs of employees (its catchment population). Services should be designed and planned to respond to those needs. The service should have an overall policy, authorised by management, that contains the mission statement and clearly states the objectives of the department.

The policy should include:

a) A commitment to comply with relevant occupational health legislation and regulation and industry requirements
b) A commitment to promote a culture of health and safety within the hospital
c) A commitment to close collaboration with the health and safety committees on all matters relating to health and safety at the hospital

The policy should be appropriate to the nature and scale of the risks specific to the hospital and, where applicable, organisational employees. The policy should be communicated to all employees.

Criteria

21.3.2.1 The Occupational Health Service has an overall policy that contains as a minimum a mission statement and points (a)–(c) set out above.

21.3.2.2 The policy is authorised by senior management.

21.3.2.3 The policy is clearly displayed within the department, communicated to all employees and available to all interested parties.

21.3.2.4 The policy is reviewed at appropriate intervals as determined by the department, but at least every three years.

21.3.2.5 The services to be offered are consistent with the mission of the department.

21.3.2.6 The services to be provided are described in the strategic plans of the department.

21.3.3 *Where students are trained as part of undergraduate or postgraduate programmes, the Occupational Health Service ensures formal training.*

Criteria

21.3.3.1 There is a designated member of the personnel of the Occupational Health Service who coordinates student training.

21.3.3.2 The training programme is structured in accordance with the guidelines of the appropriate registration body and training facilities.

21.3.3.3 Training periods are recorded and evaluated.

21.4 Provision of Occupational Health Services

21.4.1 *The functions of the occupational health practitioners are provided in accordance with ethical and professional practices and legal requirements.*

Standard Intent
Documented policies are implemented to ensure that copies of relevant current legislation are readily available and accessible. This can be either paper or electronic format. The policy should include a requirement for regular review of legislation available in the department and replacement of outdated legislation. The policy should outline procedures for the clear identification, removal and storage of outdated legislation to guard against unintended use.

Criteria

21.4.1.1 Occupational Health Services are provided in accordance with relevant standards promulgated by local, provincial and national guidelines, laws and regulations.

21.4.1.2 Copies of relevant laws and regulations are available and readily accessible.

21.4.1.3 Legislation is reviewed regularly at a frequency determined by the hospital but at least every three years and the reference records updated accordingly.

21.4.1.4 When outdated legislation is retained for future reference or research purposes, it is clearly marked as outdated, removed from the current reference documentation and stored in such a way as to guard against unintended use.

21.4.2 *The hospital provides appropriate medical care to the employees of the hospital and/or organisation.*

Standard Intent
The Occupational Health Service exists to provide appropriate medical care to employees of the hospital and/or organisation, which takes account of the employee's work environment where appropriate. Due consideration should be given to the mental as well as the physical health of the workforce.

Criteria

21.4.2.1 Occupational Health Service personnel are informed of the potential workplace hazards for each employee.

21.4.2.2 Occupational Health Service personnel have ready access to appropriate reference materials regarding occupational health care.

21.4.2.3 Where routine medical care is offered to employees by the Occupational Health Service, medical complaints by employees are differentiated in terms of workplace-related complaints and other medical conditions.

21.4.2.4 The management of medical conditions includes consideration of the relationship of the employee and the medical condition to the workplace environment and work practices.

21.4.2.5 The management of medical complaints includes consideration of the employee's fitness to continue present work practices.

21.4.2.6 The management of medical complaints includes consideration of any disability that may have been sustained.

21.4.2.7 The management of an acute injury includes measures to minimise disability and return the employee to an optimal functional state as soon as possible.

21.4.2.8 Employees are screened for mental health issues that may arise from working conditions, illness or disability and are managed appropriately.

21.4.2.9 Records reflect both screening for and management of mental health issues.

21.4.3 *Details of the hospital's and/or organisation's absenteeism and sickness rates are recorded and analysed to allow for informed decision making by the senior management team.*

Criteria

21.4.3.1 Employees who are absent from work are evaluated to ensure that they have regained sufficient health to be returned to their particular work place.

21.4.3.2 Such evaluation includes, but is not limited to, the extent and duration of the condition that caused the absence from work.

21.4.3.3 Such evaluation includes, but is not limited to, the extent and duration of potential hazards that may affect the employee's health.

21.4.3.4 Analysis of employee absenteeism and sickness provides data for risk management planning, for example analysis of back injuries causing employee sickness and absenteeism.

21.4.4 *The Occupational Health Service has an appropriate medical surveillance programme, which meets the needs of the population served.*

Standard Intent

The service should identify the risks within the hospital and/or organisation that require health surveillance as part of the risk management programme. An appropriate health surveillance programme should be designed and implemented by adequately-trained personnel. The programme should include an effective employee recall system.

The state of health of employees should be determined when they join the hospital and/or organisation and again on leaving the hospital and/or organisation as part of the health surveillance service. Employees must be aware of their right to have access to their records

Criteria

21.4.4.1 The health surveillance programme is appropriate for the health risks to which employees are exposed.

21.4.4.2 The data collection process is designed to provide information that can be used in determining measures to eliminate, control and minimise the health risks to which employees are exposed.

21.4.4.3 There is an effective employee recall system to ensure that employees are seen at appropriate intervals.

21.4.4.4 Personnel responsible for the development and implementation of the health surveillance programme are appropriately trained and updated.

21.4.4.5 Records of each employee under surveillance are appropriately stored and managed in accordance with hospital policy relating to management of information and appropriate legislation.

21.4.4.6 Records are available to the employee upon request.

21.4.4.7 Employees are aware of their right to access their records relating to the health surveillance programme.

21.4.4.8 Pre-employment examinations are conducted that consider the health of the individual and the requirements of the prospective workplace.

21.4.4.9 Pre-termination examinations are conducted when employees leave the employ of the hospital and/or organisation to provide accurate information on their state of health on departure.

21.4.4.10 Lifestyle habits (weight, diet, exercise, alcohol and/or tobacco use, etc.) are assessed when potential exposure to hazardous agents may be affected by those habits.

21.5 Health Promotion

21.5.1 *The Occupational Health Service builds capacity in the workplace through the provision of information, education and counselling services.*

Standard Intent

Occupational health practitioners play an important role in empowering the workforce to take responsibility for their own environment in addition to the responsibility of healthcare providers to provide relevant health promotion and educational messages.

Posters are a useful aid in the dissemination of relevant health information. Posters should be displayed in all appropriate areas for the purpose of providing health education to the employees specific to their health, work environment and employee rights. The posters should be appropriate for the population served in terms of language and comprehension.

The posters should provide information on:

a) Health and safety risks relevant to the work environment
b) Mental health issues relevant to the work environment
c) Encouraging compliance with measures to protect their own health and safety and that of others,
d) e.g. wearing of protective clothing and following appropriate procedures
e) The correct procedures to follow if they feel that a new risk has emerged which threatens the health and safety of the workforce or environment
f) The right of access to health records and the results of any investigations
g) The right to refuse to work in areas that they feel to be unsafe
h) Health issues such as TB, HIV and substance abuse

Relevant health education should be provided in all consultations and documented in the employee record.

Criteria

21.5.1.1 The Occupational Health Service works with the personnel of other health services, nongovernmental organisations and local governmental structures to provide health education and build capacity within the workforce.

21.5.1.2 Posters are displayed in relevant areas within the hospital covering at least points (a)-(g) in the intent statement above.

21.5.1.3 HIV counselling and screening services are offered with due regard for confidentiality.

21.5.1.4 Information provided is appropriate for the language/s and comprehension of the population served.

21.6 Communicable Diseases

21.6.1 *The Occupational Health Service undertakes monitoring and prevention measures for notifiable medical conditions and communicable diseases where relevant.*

Criteria

21.6.1.1 The Occupational Health Service identifies, investigates and monitors the outbreak of communicable disease when indicated.

21.6.1.2 The Occupational Health Service institutes the necessary corrective and preventive occupational health measures when required.

21.6.1.3 The Occupational Health Service participates in the development of necessary reaction teams in relation to municipal health measures.

21.6.1.4 The Occupational Health Service promotes health and hygiene aimed at the prevention of occupational conditions that lead to communicable diseases.

21.6.1.5 The Occupational Health Service gathers, analyses and distributes epidemiological data and information.

21.6.1.6 There is an appropriate system in place for the prompt reporting of notifiable medical conditions.

21.6.1.7 There is a system in place to ensure the referral and uptake of confirmed cases of relevant communicable diseases into appropriate treatment programmes.

21.7 Information Management

21.7.1 *There is a system to ensure that reports and records are efficiently managed with due regard for confidentiality.*

Criteria

21.7.1.1 There is documented evidence that occupational health practitioners write reports on occupational health-related issues.

21.7.1.2 There is documented evidence that occupational health practitioners write letters and serve notices to remedy occupational health problems.

21.7.1.3 There is documented evidence that occupational health practitioners record and file health-related statistics and evaluate trends.

21.7.1.4 There is documented evidence that occupational health practitioners complete questionnaires from an occupational health perspective.

21.7.1.5 There is documented evidence that occupational health practitioners provide reports and comments on inspections, complaints, investigations.

21.7.1.6 There is documented evidence that occupational health practitioners compile occupational health report forms.

21.7.1.7 There is documented evidence that occupational health practitioners utilise standard or prescribed occupational health report forms or recording systems in respect of inspections, investigations and work of a recurring nature, e.g. notifiable medical conditions.

21.7.1.8 Personal information about an employee that is unrelated to the ability to perform the specified job safely is handled in a confidential manner.

21.7.1.9 Signed consent is obtained from employees prior to the release of any employee-related information.

21.7.2 *The organisation establishes, implements and maintains procedures for controlling relevant documents and data.*

Criteria

21.7.2.1 Current versions of relevant documents and information are available at all locations where operations essential to the effective functions of the Occupational Health Service are performed.

21.7.2.2 Documents and information are periodically reviewed and revised as necessary and approved by an authorised person.

21.7.2.3 Obsolete documents and information are promptly marked as such and removed from all points of issue and points of use or otherwise assured against unintended use.

21.7.2.4 Archival documents and information retained for legal or knowledge preservation purposes or both are suitably identified.

21.8 Quality Management and Improvement

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

Standard Intent

This refers to the implementation of hospital quality improvement processes.

It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards

are set for the particular department. This requires coordination with the hospital's central management/coordinating quality improvement structures. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.

The following will be evaluated:

- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals are not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of employee care, but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

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

21.8.1.2 Indicators of performance are identified to evaluate the quality of treatment and employee care.

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

21.8.1.4 A documentation audit system is in place.

21.9 Employee Rights

21.9.1 *The department/service implements processes that support employee rights during care.*

Standard Intent

This refers to the implementation of hospital policies on employee and family rights (Service Element 4).

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

Criteria

21.9.1.1 There are processes that support employee rights during care.

21.9.1.2 Measures are taken to protect the employee's privacy, person and possessions.

21.9.1.3 The personnel respect the rights of employees to treatment and to refuse treatment.

21.10 Prevention and Control of Infection

21.10.1 *The department/service implements infection prevention and control processes.*

Standard Intent

The health of occupational health personnel, like that of all healthcare workers, should be protected from work-related risks. Healthcare workers are at higher risk of contracting infectious diseases and, as such, appropriate measures should be in place to minimise these risks.

Criteria

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

21.10.1.2 Individuals who collect specimens are trained in the proper collection and handling of microbiological specimens.

21.10.1.3 Hospital policies and procedures for the prevention and control of infection are readily available in the department.

21.10.1.4 Policies and procedures address the correct management of sharps within the department.

21.10.1.5 Post exposure prophylaxis kits are readily available for personnel and employees who sustain needlestick injuries.

21.10.1.6 Information regarding needlestick injuries is recorded and action taken as appropriate.

21.10.1.7 Personnel and employees are routinely offered BCG and vaccination for Hepatitis B.

21.10.1.8 Sero-conversion is measured and recorded in personnel folders.

21.10.1.9 Booster vaccinations are offered as appropriate.

21.11 Risk Management

21.11.1 *Risks to the health and safety of personnel, employees or visitors are assessed and control measures introduced in order to minimise or eliminate risk and promote safety.*

Standard Intent

The goal is to prevent accidents and injuries, maintain safe and secure conditions for employees, personnel and visitors and reduce and control hazards and risks.

This can be done by comprehensively inspecting the work environment of the catchment population of the department, with particular reference to hazardous processes, equipment, substances, procedures and environments. This periodic inspection must be documented and will help the organisation to plan and implement improvements and budget for longer-term facility upgrading or replacement. Then, with an understanding of the risks present in the hospital's physical facility, the senior management team can develop a proactive plan to reduce those risks for employees, personnel, employees and visitors. This plan should include safety, security and hazardous materials.

Criteria

21.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of the risk management programme.

21.11.1.2 Occupational health personnel are included in the assessment of risks to the health of employees attached to any work.

21.11.1.3 Occupational health personnel have access to and utilise consultative services associated with evaluating workplace hazards such as industrial hygiene, workplace toxicology, ergonomics and epidemiology.

21.11.1.4 There are monitoring mechanisms to ensure that employees adhere to safe systems of work, including the use of protective clothing.

21.11.1.5 Vulnerable groups of workers are identified.

21.11.1.6 Where there is risk of injury, it has been determined whether it is possible to avoid manual handling, or to provide mechanical aids in place of the latter.

21.11.1.7 There is a mechanism to ensure that employees are aware of risks and their consequences.

21.11.1.8 Documented information on the safe handling and storage of hazardous substances is available and provided to the management of the hospital.

21.11.1.9 First aid is available to employees.

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

21.11.1.11 Security measures are in place and implemented to safeguard and protect employees, personnel and visitors.

21.11.1.12 Fire safety measures are implemented.

21.11.1.13 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

22 Laboratory Service

OVERVIEW OF LABORATORY SERVICE

Laboratory investigations and rapid reporting systems are essential for patient assessment and the implementation of treatment plans.

The hospital may have its own laboratory service, or it may have an arrangement with an outside laboratory service, for accepting laboratory specimens for analysis. In either case, the service must meet applicable laws and regulations.

The selection of an outside source must be based on an acceptable record of accurate, timely service and compliance with laws and regulations

Laboratory services must be available at those times needed by the hospital, including emergency and after-hours services.

The standards consider recommendations of relevant bodies. These include the World Health Organisation, the International Standards Organisation (ISO) and the International Accreditation Forum (IAF).

22.1 Management of the service

22.1.1 *Laboratory services are available to meet the needs of patients in compliance with local and national Namibian laws, regulations and standards.*

Standard Intent

The hospital is responsible for providing laboratory services, including clinical pathology services, which meet the needs of its patient population, the clinical services offered and the healthcare providers.
The laboratory services are organised and provided in a manner that meets applicable local and national Namibian standards, laws and regulations.

Laboratory services, including those required for emergencies and after-hours, may be provided within the hospital, by agreement with another organisation, or both if outside sources are convenient for the patient to access. The hospital must select outside sources based on the recommendations of the director or other individual responsible for laboratory services. Outside sources of laboratory services must have an acceptable record of accurate, timely services. Patients must be informed when an outside source of laboratory services is owned by the referring physician.

Criteria

22.1.1.1 Adequate, convenient and regular laboratory services are available to meet the hospital's needs.

22.1.1.2 Where laboratory services are outsourced, the hospital has a valid service level agreement with an accredited laboratory.

22.1.1.3 The laboratory services are organised and provided in a manner that meets applicable local and national standards, laws and regulations.

22.1.1.4 Emergency laboratory services are available, including after-hours services.

22.1.1.5 The hospital has established the expected turnaround times for results.

22.1.1.6 Laboratory results are reported within the agreed turnaround times.

22.1.2 *A qualified individual is responsible for managing the Laboratory Service.*

Standard Intent
The Laboratory Service must be under the direction of an individual who is qualified by virtue of documented training, expertise and experience, in accordance with applicable Namibian laws and regulations. This individual must assume professional responsibility for the laboratory facility and for the services provided.

When this individual provides clinical consultations or medical opinions, he or she must be a physician, preferably a pathologist.

Speciality and subspecialty laboratory services must be under the direction of appropriately qualified individuals.
Responsibilities of the laboratory director include the:

- Ordering of tests
- Collecting and identifying of specimens
- Transporting, storing and preserving of specimens
- Receiving, logging in and tracking of specimens

These procedures must also be observed for specimens sent to outside sources for testing.

Criteria
22.1.1.7 The laboratory is under the direction of a qualified individual.

22.1.1.8 The responsibilities of this person include maintaining quality control programmes.

22.1.1.9 The responsibilities of this person include administrative supervision.

22.1.1.10 The responsibilities of this person include the monitoring and reviewing of all laboratory services.

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

Standard Intent
The hospital must identify which laboratory personnel may perform testing and who may direct or supervise testing. Supervisory personnel and technical personnel must have appropriate and adequate training, experience and skills and be oriented to their work. Technical personnel must be given work assignments consistent with their training and experience. In addition, there should be sufficient personnel to perform tests promptly and provide the necessary laboratory staffing during all hours of operation, including for emergencies.

The hospital must be able to identify and contact experts in specialised diagnostic areas when needed, e.g. parasitology or virology.

Criteria
22.1.1.11 Those individuals who may perform testing and those who may direct or supervise testing are identified.

22.1.1.12 Appropriately trained and experienced personnel administer tests.

22.1.1.13 Appropriately trained and experienced personnel interpret tests.

22.1.1.14 Laboratory results are validated and include unique patient identities, the date of testing/reporting, name and location of requesting physician.

22.1.1.15 The validating officer is identified and recorded.

22.1.1.16 There is an adequate number of personnel to meet patient needs.

22.1.1.17 A roster of experts for specialised diagnostic areas is maintained.

22.1.1.18 There is a record of each test done, by whom, the result thereof and a monthly summary.

22.2 Facilities and equipment

22.1.4 *Laboratory buildings are adequate to provide a safe and effective laboratory service.*

Standard Intent
Departmental managers need to work closely with hospital managers to ensure that facilities and equipment available are adequate for the service provision required. Departmental managers must keep hospital managers informed about inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

The general state of the laboratory will be checked. The walls, floor and ceiling should be in a good condition. As few items/instruments as possible should be placed on the floor.

Criteria

22.2.1.1 The laboratory is a separate designated area within, or near, the hospital.

22.2.1.2 The size of the laboratory is appropriate to the services provided.

22.2.1.3 The walls, ceilings and floors are smooth, easy to clean, impermeable to liquids and resistant to chemicals.

22.2.1.4 Hand washing facilities with running water are provided in each laboratory room, preferably near the exit door.

22.2.1.5 Separate facilities are provided for personnel to store personal items.

22.2.1.6 Separate rest-room facilities where personnel can eat and drink are available.

22.2.1.7 Laboratory fixtures and fittings are adequate to provide a safe and effective laboratory service.

22.1.5 *Laboratory fixtures and fittings are adequate to provide a safe and effective laboratory service.*

Standard Intent
The laboratory should be constructed in such a way that it can provide the projected laboratory services. The laboratory should have sufficient properly constructed laboratory benches, washing and staining facilities, sufficient power and water and preferably a controlled temperature.

Specific details that should be monitored include:

- Laboratory benches and equipment should be of a material that can support the laboratory instruments (strong) and cannot affect the surface of the table.
- Preferably the laboratory tables should be constructed of concrete that is tiled.
- Wooden tables are not acceptable.
- At least one washing unit must be available for standard cleaning and washing activities.
- When staining is performed, two units are preferred.
- The number and quality of the available sockets should be sufficient for the projected activities.

The water supply should be guaranteed, to provide washing and staining activities.

Criteria

22.2.1.8 There are sufficient laboratory benches for the projected activities.

22.2.1.9 Laboratory benches are strong enough for the projected activities (e.g. large instruments).

22.2.1.10 Space around and under benches should allow for ease of cleaning and maintenance.

22.2.1.11 Storage space is adequate to hold supplies for immediate use and to prevent clutter of bench tops.

22.2.1.12 There is either an uninterrupted power supply (UPS) or battery backup system, and an automated voltage stabiliser (AVS) present for critical equipment, which are tested regularly, and the results of testing are fully documented.

22.2.1.13 Each laboratory compartment has adequate ventilation, room temperature is maintained below 25°C and a temperature record is kept.

22.2.1.14 There is adequate laboratory equipment to provide a safe and effective laboratory service.

22.1.6 *There is adequate laboratory equipment to provide a safe and effective laboratory service.*

Standard Intent

In order to provide effective laboratory services, it is essential that specific equipment is available. Laboratory management and personnel are responsible for the selection and availability of the critical instruments, their operation according to manufacturer's instructions and their appropriate maintenance.

- The following must be considered:
- Processes for the selection, procurement and replacement of instruments
- The availability of an equipment inventory management system
- The maintenance of the available equipment through inspection, testing and calibration
- Monitoring of and acting on equipment hazard notices, recalls, reportable incidents, problems and failures
- The availability of a system where activities are documented

Testing, maintenance and calibration frequency are related to the laboratory's use of equipment and its documented history of service.

A named person should be responsible for monitoring the temperature of the specimen refrigerator, which must be maintained between 2 and 6 degrees centigrade, and other refrigerators in the laboratory

Criteria

22.2.1.15 Sufficient equipment is available to provide the required laboratory services for the projected activities.

22.2.1.16 All equipment is in good working order, operated appropriately and functioning well.

22.2.1.17 There are laboratory equipment management processes.

22.2.1.18 The processes include selecting, acquiring and replacing of equipment.

22.2.1.19 The processes include taking an inventory of the equipment.

22.2.1.20 The processes include monitoring and follow-up.

22.2.1.21 There is adequate documentation of all testing, maintenance and calibration of equipment.

22.3 Reagents, chemicals and kits

22.1.7 *The supplies of laboratory consumables, reagents, chemicals and kits are adequate to provide a safe and effective laboratory service.*

Standard Intent

The hospital should identify those reagents and supplies required to deliver the necessary laboratory services to its patients. There should be an effective process for ensuring that essential reagents and other supplies are available at all times. All reagents should be stored and dispensed according to defined procedures. The periodic evaluation of all reagents, e.g. monitoring of expiry dates, will ensure accurate and precise results. Documented procedures should be available to ensure the complete and accurate labelling of reagents and solutions.

Criteria

22.3.1.1 The available supplies, consumables, reagents, chemicals and kits are sufficient for projected activities.

22.3.1.2 Specific laboratory reagents, chemicals and kits are used appropriately.

22.3.1.3 All reagents and chemicals are stored and dispensed according to guidelines.

22.3.1.4 All reagents and solutions are completely and accurately labelled.

22.3.1.5 All reagents are periodically evaluated for accuracy and results.

22.3.1.6 All reagents are stored in a lockable storage room or cupboard.

22.3.1.7 A named person is responsible for the specimen and reagent fridges.

22.4 Management of specimens and results

22.1.8 *Procedures are followed for collecting, identifying, transporting and tracking specimens or samples and reporting the results.*

Standard Intent
Procedures must be developed and implemented for:

- Requesting laboratory tests (laboratory request form)
- Specimen collection and identification
- Specimen storage, preservation and transport
- Reviewing and authorising the laboratory results

There should be at least two log-books: only one patient log-book and at least one log-book for laboratory results. Dependent upon the size of the provider and the national requirements of the Ministry of Health or equivalent, different log books for various disciplines may be required or mandatory. Log-books for laboratory results should not be directly linked to names. Patient log-books should contain name, date of visit, date of birth, gender, which services are requested, what material should be collected and the unique laboratory identification number. In the laboratory log-books only the unique laboratory number and results should be registered. In other words, both log-books are required to match results to patient names.

Ideally, monthly overviews of the number of tests performed should be generated. Procedures should be available for administration, collection and reporting activities of specimens tested on site or sent to outside referral laboratories.

Criteria

22.4.1.1 Policies and procedures or standard operating procedures (SOPs) for handling specimens are implemented.

22.4.1.2 Request forms and specimen labels include unique patient identifiers and adequate supporting information.

22.4.1.3 There is a collection and delivery service for specimens from the hospital, every weekday.

22.4.1.4 Specimens are given a laboratory specimen accession number.

22.4.1.5 Procedures guide the ordering of tests.

22.4.1.6 Procedures guide the collection and identification of specimens.

22.4.1.7 Procedures guide the transport, storage and preservation of specimens.

22.4.1.8 Procedures guide receiving, logging-in and tracking of specimens.

22.4.1.9 Emergency results may be obtained by telephone.

22.1.9 *Established norms and ranges are used to interpret and report clinical laboratory results.*

Standard intent
The laboratory must establish reference intervals or "normal" ranges for each test performed. The range must be included in the clinical record, either as part of the report or by including a current listing of such values, approved by the laboratory director.

Ranges should be provided when an outside source performs the test. The reference ranges must be appropriate to the hospital's catchment population and should be reviewed and updated when methods change.

Criteria

22.4.1.10 Policies and procedures or standard operating procedures regarding reporting and reviewing results are implemented.

22.4.1.11 The laboratory has established reference ranges for each test performed.

22.4.1.12 The range is included in the clinical record at the time test results are reported.

22.4.1.13 Ranges are provided when tests are performed by outside sources.

22.4.1.14 Ranges are appropriate to the hospital's catchment population.

22.4.1.15 Ranges are reviewed and updated, as needed.

22.5 Quality management

22.1.10 *Quality control procedures are implemented and documented.*

Standard Intent

The quality of the laboratory services can be monitored using internal and external quality control guidelines. Designing and implementing internal and external quality control activities is essential for the final quality assurance of the laboratory results.

Sound quality control systems are essential to providing excellent pathology and clinical laboratory services.

Quality control procedures could include:

- Validation of the test methods used for accuracy, precision and reportable range
- Daily surveillance of results by qualified laboratory facility
- Rapid corrective action when a deficiency is identified
- Testing of reagent
- Documentation of results and corrective actions

Proficiency testing determines how well an individual laboratory's results compare with other laboratories that use the same methodologies. Such testing can identify performance problems not recognised by internal mechanisms. Therefore, the laboratory should participate in an approved proficiency testing programme when one is available.

Alternatively, when approved programmes are not available, the laboratory should exchange samples with a laboratory in another hospital for peer comparison testing purposes. The laboratory must maintain a cumulative record of participation in a proficiency testing process. Proficiency testing or an alternative must be carried out for all speciality laboratory programmes, when available.

Criteria

22.5.1.1 There is a quality control process for the clinical laboratory.

22.5.1.2 The process includes the validation of test methods.

22.5.1.3 The process includes the daily surveillance of test results.

22.5.1.4 The process includes the rapid correction of deficiencies.

22.5.1.5 There is a current register of quality control results and of the corrective and preventive actions taken.

22.5.1.6 The laboratory participates in a proficiency testing programme, or an alternative, for all speciality laboratory services and tests.

22.5.1.7 A cumulative record of participation is maintained.

22.5.1.8 The hospital regularly reviews quality control results from all outside sources of laboratory services.

22.5.1.9 Copies of the quality control audits for the past six months verify that accurate/reliable results are being provided.

22.5.1.10 22.5.2. A formalised, proactive quality improvement approach is maintained in the service.

22.1.11 *A formalised, proactive quality improvement approach is maintained in the service.*

Standard Intent

This refers to the implementation of hospital quality improvement process (Service Element 7). The senior management team is responsible for ensuring that standards are set throughout the hospital. Within each department or service, unit managers should ensure that standards are set for the particular unit. Departmental or service managers should use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structure(s) to ensure coordinated quality improvement activities throughout the hospital

The following will be evaluated:

- The manner in which problems were identified and prioritised in this service, for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project, such as acquiring a specific item of equipment, will be scored NC. Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, e.g. monitoring the temperature of the refrigerator over time, will be scored PC.

Criteria

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

22.5.1.12 Indicators of performance are identified to evaluate the quality of service offered by the laboratory.

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

22.5.1.14 A documentation audit system is in place.

22.6 Patient rights

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

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4).

Criteria

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

22.6.1.2 Measures are taken to protect the confidentiality of patient information and, where relevant, the patient's privacy, person and possessions.

22.6.1.3 Personnel respect the rights of patients and families to treatment and to refuse treatment.

22.7 Prevention and control of infection

22.1.13 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

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

22.7.1.2 Personal protective equipment, including eye protection, is available to all personnel.

22.7.1.3 Individuals who handle specimens are trained in the correct handling of dangerous specimens.

22.7.1.4 Suitable processes are followed for cleaning and decontamination of laboratory surfaces and equipment.

22.8 Risk management

22.1.14 *The department/service implements risk management processes.*

Standard intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

22.8.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

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

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

Fire safety measures are implemented.

22.8.1.4 The hospital's policy on handling, storing and disposing of healthcare waste is implemented.

23 Radiology and Diagnostic Imaging Service

OVERVIEW OF RADIOLOGY AND DIGNOSTIC IMAGING SERVICE

The hospital is responsible for ensuring that the radiology and diagnostic imaging service meets the needs of its patient population, the clinical services offered and the healthcare providers.

These needs may be met by a service within the hospital, or may be outsourced. In either case, the radiology and diagnostic imaging service must comply with all applicable local and national standards and legislation.

Where a radiology and diagnostic imaging service is provided by the hospital, the hospital leaders must ensure that there are radiation safety programmes in place and that individuals with adequate training, skills, orientation and experience are available to undertake diagnostic imaging procedures and interpret the results.

This document addresses the requirements for conventional X-ray imaging techniques, but the principles can also be applied to other/specialised diagnostic imaging techniques such as computed tomography (CT), nuclear medicine (scintigraphy), ultrasonagraphy and magnetic resonance imaging (MRI).

The radiology and diagnostic imaging service should allow for immediate decision-making by practitioners through the provision of emergency services and emergency reports, as necessary.

23.1 Management of the Service

23.1.1 *A radiology and diagnostic imaging service is provided by the hospital, or is readily available through arrangements with outside sources, to meet the needs of its catchment population.*

Standard Intent

The hospital must have a system for providing the radiology and diagnostic imaging services required by its catchment population, the clinical services offered and healthcare provider needs.
Radiology and diagnostic imaging services, including those required for emergencies, may be provided within the hospital, by agreement with another organisation, or both. The radiology and diagnostic imaging service must be available after normal hours for emergencies.

Outside sources should be convenient for the patient to access and reports should be received in a timely manner to support continuity of care. These outside sources should be selected by the hospital on the recommendation of the director or another individual responsible for radiology and diagnostic imaging services. In addition, these outside sources must meet applicable Namibian laws and regulations and have an acceptable record of accurate, timely service. Patients must be informed when the referring physician owns, or has a financial interest in, the outside source of radiology and diagnostic imaging.

Criteria

23.1.1.1 An adequate, convenient and regular radiology and diagnostic imaging service is available to meet patient needs.

23.1.1.2 Where radiology and diagnostic imaging services are outsourced, the hospital has a valid service level agreement with an accredited radiology service.

23.1.1.3 The selection of an outside source is based on an acceptable record of accurate, timely service and compliance with applicable laws and regulations.

23.1.1.4 An emergency radiology and diagnostic imaging service is available after hours.

23.1.2 *A qualified individual is responsible for managing the radiology and diagnostic imaging service.*

Standard Intent

The radiology and diagnostic imaging service must be under the direction of an individual who is qualified by virtue of documented training, expertise and experience, in accordance with applicable laws and regulations. This individual must assume professional responsibility for the radiology and diagnostic imaging service. When this individual is responsible for providing clinical consultations or a medical opinion, he or she must be a physician, preferably a radiologist.

The radiology and diagnostic imaging director's responsibilities should include:

- Developing, implementing and maintaining policies and procedures
- Administrative control
- Maintaining any necessary quality control programmes
- Recommending outside sources of radiology and diagnostic imaging services

Monitoring and reviewing all radiology and diagnostic imaging services

Criteria

23.1.2.1 A radiologist or radiographer, who is qualified by education, training and experience, manages the radiology and diagnostic imaging service.

23.1.2.2 The responsibilities of this person include developing, implementing and maintaining relevant policies and procedures.

23.1.2.3 The responsibilities of this person include administrative control.

23.1.2.4 The responsibilities of this person include maintaining quality control programmes.

23.1.2.5 The responsibilities of this person include recommending outside sources of radiology and diagnostic imaging services.

23.1.2.6 The responsibilities of this person include monitoring and reviewing all radiology and diagnostic imaging services.

23.1.3 *Individuals with adequate training, skills and experience perform diagnostic imaging procedures and interpret the results.*

Criteria

23.1.3.1 Those individuals who may perform diagnostic imaging procedures and those who may interpret and report the results are identified.

23.1.3.2 A system is in place to ensure that procedures are performed only by radiographers, radiologists, or specially trained doctors and other persons, authorised to do so by a radiation protection advisor.

23.1.3.3 Diagnostic imaging is done only upon a signed request from a qualified medical practitioner.

23.1.3.4 Diagnostic images are interpreted and reported on by appropriately trained and experienced personnel.

23.1.3.5 There is an adequate number of personnel to meet patient needs.

23.1.3.6 Experts in specialised diagnostic areas are contacted, when needed.

23.1.3.7 A roster of experts for specialised diagnostic areas is maintained.

23.2 Patient and Personnel Safety

23.2.1 *Measures to protect patients and personnel from unnecessary exposure are applied.*

Standard Intent
The ALARA (As Low As Reasonably Achievable) principle should be applied to diagnostic imaging examinations in order to obtain optimal images, while keeping the radiation dose as low as possible. The WHO indentifies factors to minimise radiation dose to patients and personnel that are within the control of the radiographer, which include the following:

- Limitation of field size to the area of interest
- Use of fast screen-film combinations whenever appropriate
- Optimal film processing
- Use of automatic exposure times if available
- Use of gonad shields
- Selection of grid
- Compression of obese patients
- Highest practicable kV and lowest mAs
- Reduction of the number of repeat images by careful patient positioning and use of immobilisationdevices
- Performance of basic quality assurance tests
- No continuous radiation during fluoroscopy
- Field size to be smaller than screen size during fluoroscopy
- Only required personnel allowed into the room during radiographic examinations
- X-ray units must have adequate shielding
- All personnel should stand behind a protective barrier during exposure
- Personnel who are required outside the barrier must wear lead-rubber aprons
- Personnel should stand outside the path of the primary beam and as far away as possible
- Lead-rubber flaps to be used on image intensifiers to reduce scatter to personnel

(WHO Basics of Radiation Protection for Everyday Use 2004 pg 8)

Criteria

23.2.1.1 Warning signs are placed at the entrances to X-ray rooms.

23.2.1.2 Notices encouraging women to inform the radiographer of pregnancy are prominently displayed.

23.2.1.3 Dosimeter badges are worn and handled according to Ionising Radiation regulations.

23.2.1.4 Documented systems are in place to ensure that pregnant radiographers/technicians are provided with additional radiation monitoring devices and are restricted to work in low risk areas.

23.2.1.5 Protective clothing and appliances for personnel and patients are available and in good order.

23.2.1.6 A documented system is in place to ensure that doors are closed during radiographic examinations.

23.2.1.7 Beam restricting devices are used.

23.2.1.8 Each X-ray room is provided with an exposure chart.

23.2.1.9 Each X-ray machine is provided with a log-book, which includes quality control information on the device.

23.2.2 *Essential resuscitation equipment and medications are available.*

Standard Intent

Every patient care area, including the diagnostic imaging department, must have access to a defibrillator or automated external defibrillator (AED) within three minutes of any patient who suffers a cardiac arrest. A resuscitation trolley must be available within one minute of any patient who collapses.

In addition to the background risk of patient collapse due to illness, certain imaging techniques require the administration of contrast media to patients, which may result in an adverse drug reaction of varying severity, including anaphylaxis. The diagnostic imaging department must be equipped to manage this risk adequately.

Resuscitation equipment available to the department must include at least:

a) An ECG monitor
b) A CPR board (if required)
c) Suction apparatus (electrical and/or alternative) plus range of soft and hard suction catheters
d) d) A bag-mask manual ventilator
e) Range of endotracheal tubes and two laryngoscopes, with a range of straight and curved blades, spare batteries and spare globes where applicable
f) Introducer/stylet for endotracheal intubation
g) Syringe to inflate endotracheal tube cuff
h) Oropharyngeal tubes
i) Equipment to perform an emergency cricothyroidotomy by either surgical means or by using a needle
j) Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
k) Drugs for cardiac arrest, coma, fits and states of shock (including paediatric doses)
l) A defibrillator or automated external defibrillator (AED) with adult paddles/pads (and infant paddles/pads where applicable) within three minutes of any patient collapsing

Designated personnel must ensure that equipment checks are carried out daily or after each use, whichever comes first. Records of these tests must be maintained. Policies and procedures detailing what these checks will encompass and who will be responsible for their implementation must be in place. Policies and procedures as well as evidence in the form of a log-book or similar record system are required.

Checklists should be available and should indicate both the recommended minimum quantities and the quantities actually present. These checks must also include expiry dates with regard to all limited lifespan items such as medication, ECG electrodes, tubes, catheters, etc.

Criteria

23.2.2.1 There is a mechanism for the summoning of medical help in an emergency.

23.2.2.2 Resuscitation equipment is available in accordance with hospital policy and includes (a)-(l) in the standard intent above as a minimum.

23.2.2.3 Resuscitation equipment and drugs are checked daily or immediately after use, whichever is the sooner, by persons identified to be responsible for this.

23.3 Reporting and Recording

23.3.1 *Reporting and recording policies and procedures within the radiology and diagnostic imaging service ensure safety and legality.*

Standard Intent

Diagnostic imaging request forms and the ensuing reports must identify the correct patient and the correct site to be examined. The hospital should define the time period for reporting diagnostic radiology and diagnostic imaging test results. Results must be reported within a time frame based on patients' needs, services offered and clinical personnel's needs. Mechanisms are in place to ensure that diagnostic imaging reports are available immediately in an emergency.

The images are the property of the patient and may be taken away by the patient. Where this is done, he/she should be advised to bring the images to any future visits.

Criteria

23.3.1.1 Diagnostic imaging request forms contain the patient's name, examination requested, relevant previous examinations and clinical information to explain the request.

23.3.1.2 The request form includes information regarding previous investigations.

23.3.1.3 The hospital has established the expected report time for results.

23.3.1.4 Radiology and diagnostic imaging results are reported on within a time frame to meet patient needs.

23.3.1.5 There is a method of checking the reports against the clinical records.

23.3.1.6 Reports contain a clear conclusion and recommendations for future treatment where appropriate.

23.3.1.7 A copy of the report is filed in the patient's record.

23.3.1.8 Images are available at each visit of the patient.

23.3.1.9 A policy that defines the duration and method of storage of images is implemented.

23.3.1.10 Where digital imaging is used, appropriate back-up services are available.

23.3.2 *The radiology and diagnostic imaging service meets applicable local and national standards and legislation.*

Standard Intent
The hospital must ensure that personnel are knowledgeable about the relevant legal requirements relating to radiology and diagnostic imaging. This can be achieved by ensuring that copies of local legislation and/or regulations relating to current Ionising Radiation and other relevant documents are available to personnel in the department.

The hospital must satisfy the statutory requirements under the Ionising Radiation regulations, which must be evident in the most recent radiation safety report.

The hospital must have arrangements in place to ensure that advice on radiation protection and how to deal with a suspected case of overexposure can be obtained when required.

Criteria

23.3.2.1 Documented policies and procedures that address compliance with applicable standards, laws and regulations are implemented.

23.3.2.2 A copy of the local rules relating to current Ionising Radiation regulations is available.

23.3.2.3 A copy of the most recent radiation safety report is held.

23.3.2.4 The hospital satisfies the statutory requirements under Ionising Radiation regulations.

23.3.2.5 A radiation protection supervisor is identified and available to assist a radiation protection adviser in complying with the Ionising Radiation regulations.

23.3.2.6 A patient register is held in the radiology and diagnostic imaging department.

23.3.3 *X-ray film and other supplies are regularly available.*

Standard Intent
The hospital should identify the quantities of film, reagents and supplies necessary to provide a radiology and diagnostic imaging service to its patients. A process to order or secure essential film, reagents and other supplies should be effective. All supplies should be stored and dispensed according to defined procedures. The periodic evaluation of reagents will ensure accuracy and precision of results. Documented guidelines should be available and followed to ensure the complete and accurate labelling of film, reagents and solutions.

Criteria

23.3.3.1 Essential quantities of film, reagents and supplies are available.

23.3.3.2 All film and reagents are stored and disposed of according to guidelines.

23.3.3.3 All reagents and solutions are completely and accurately labelled.

23.4 Medication Management

23.4.1 *Medications are ordered according to hospital policy and stored in a secure and clean environment.*

Standard Intent
Medication is administered to patients in the diagnositic imaging department for the purpose of contrast investigations, e.g. IVP, Ba enema, angiography, etc. Where this medication is stored in the department, arrangements must be in place to ensure that these medications are managed in accordance with hospital policy.

Each hospital must identify those individuals permitted to order medication. These individuals must have the knowledge and experience required by Namibian law, registration or regulations to be permitted to order medications. The hospital must identify any additional individuals permitted to order medications in emergency situations.

Medication must be stored in a clean and secure environment that complies with legislation, regulations and professional practice standards.

Medications must be clearly labelled, correctly stored and protected from heat, light and moisture where necessary.

Criteria

23.4.1.1 Medication is ordered according to hospital policy.

23.4.1.2 All storage areas for medicines and pharmaceutical supplies comply with current pharmaceutical acts and regulations and manufacturer guidelines.

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

23.4.1.4 Medications are securely and legibly labelled with relevant information as required by legislation and hospital policy.

23.4.1.5 Medications are stored in a clean environment.

23.4.1.6 Expiry dates, including those of emergency drugs, are checked regularly at defined intervals according to hospital policy and drugs are replaced before the expiry date.

23.4.2 *Medication use throughout the hospital complies with applicable Namibian laws and regulations.*

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

Each hospital should identify those individuals permitted to prescribe medication. These individuals must have the requisite knowledge and experience, and be permitted by law, registration or regulations to prescribe medications. The hospital should identify any additional individuals permitted to prescribe medications in emergency situations. Prescription of medication and verbal medication orders should be issued and documented according to hospital policy.

The safe administration of medications requires adherence to a strict and comprehensive protocol. The protocol relating to the administration of medication into catheters and tubing must include steps to ensure that the tubing is checked prior to administration to ensure that medication is not administered via the wrong route. It is advisable for high risk catheters to be labelled, indicating which type of catheter it is, e.g. arterial, epidural and intrathecal catheters. Only personnel who are suitably trained and experienced must be permitted to administer medication to patients and this responsibility must be documented.

The patient, medical practitioner, nurse and other care providers should work together to monitor patients on medications. The purpose of monitoring is to evaluate the patient's response to medication, adjust the dosage or type of medication when needed and to identify, record and report any adverse effects the patient may suffer as a result of the medication.

Doctors, nurses and pharmacists are expected to report adverse reactions that are suspected to be related to medication, irrespective of whether the reaction is well recognised, potentially serious or clinically "insignificant". The hospital must ensure that Namibian requirements for the reporting of adverse drug reactions are followed.

In addition to the reporting of adverse drug reactions, there must be a system for the reporting and investigation of medication errors. The system must focus on the prevention of medication errors through understanding the types of error that occur. Each error should be investigated to understand why it happened. Where necessary, processes should be adapted to incorporate measures which will reduce the likelihood of recurrence of the error. Personnel training, either in existing or adapted medication administration processes, can be helpful in preventing future errors. Pharmacy personnel should participate in such training interventions.

Criteria

23.4.2.1 Policies and procedures that guide the safe prescribing and administration of medications are implemented.

23.4.2.2 Only those permitted by the hospital and by relevant laws and regulations prescribe medication.

23.4.2.3 Only those permitted by the hospital and by relevant laws and regulations administer medications.

23.4.2.4 Verbal and telephonic medication prescriptions are documented according to hospital policy.

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

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

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

23.4.2.8 Healthcare professionals monitor medication effects on patients collaboratively.

23.4.2.9 Adverse drug reactions (ADR) are observed, recorded and reported through a process and within a time frame defined by the hospital.

23.4.2.10 Medication errors are reported through a process and within a time frame defined by the hospital.

23.5 Quality Improvement

23.5.1 *Quality control procedures are implemented and documented.*

Standard Intent
Sound quality control systems are essential to providing excellent radiology and diagnostic imaging services. Quality control procedures include:

- Daily surveillance of imaging results by qualified radiology personnel
- Rapid corrective action when a deficiency is identified
- Testing of reagents and solutions

Documentation of results and corrective actions

Criteria

23.5.1.1 There is a quality control process for the radiology and diagnostic imaging service which is implemented.

23.5.1.2 Quality control includes daily surveillance of imaging results.

23.5.1.3 Quality control includes rapid correction when a deficiency is identified.

23.5.1.4 Quality control includes equipment maintenance/testing/safety.

23.5.1.5 Quality control includes documenting results and corrective actions.

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

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team is responsible for ensuring that standards are set throughout the hospital. Within each department or service, unit managers must ensure that standards are set for the particular unit. Departmental or service managers must use available data and information to identify priority areas for quality monitoring and improvement. This should be done in collaboration with the hospital's central quality management structure(s) to ensure coordinated quality improvement activities throughout the hospital.

Quality monitoring could include:

- Request forms without history or clinical diagnosis
- Number of unidentified patients
- Unescorted patients arriving at the department
- Waiting times
- Patient and family expectations and satisfaction

The following will be evaluated:

- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators

- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, e.g. monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

23.5.2.1 There are formalised quality improvement processes for the service, which have been developed and agreed upon by the personnel of the service.

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

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

23.5.2.4 A documentation audit system is in place.

23.6 Patient Rights

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

Standard Intent

This refers to the implementation of hospital policies on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

23.6.1.1 There are processes which support patient and family rights during care.

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

23.6.1.3 Personnel respect the rights of patients and families to treatment and to refuse treatment.

23.7 Prevention and Control of Infection

23.7.1 *The department/service implements infection prevention and control processes.*

Standard Intent

This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

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

23.7.1.2 Infection control processes include prevention of the spread of respiratory tract infections and focus on processes that may lead to infection.

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

23.8 Risk Management

23.8.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

23.8.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of the hospital programme.

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

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

23.8.1.4 Fire safety measures are implemented.

23.8.1.5 Hospital policy on handling, storing and disposing of healthcare waste is implemented.

24 Nuclear Medicine Service

OVERVIEW OF NUCLEAR MEDICINE SERVICE

Hospitals may provide nuclear medicine services as part of an integrated system of services or may have an arrangement with an outside source for the referral of patients.

The selection of an outside source should be based on an acceptable record and compliance with laws and regulations.

Where the hospital provides its own nuclear medicine services, these comply with applicable local and national standards, laws and regulations.

Radiation safety programmes must be complied with and policies and procedures should be available to guide personnel in the application of safety measures.

24.1 Referral services

24.1.1 *Where there is an arrangement with an outside service, this service meets applicable local and national Namibian standards, laws and regulations.*

Standard Intent

The hospital should have a system for providing nuclear medicine services required by its catchment population, clinical services offered, and healthcare provider needs. These services may be provided by agreement with another hospital. The hospital should define the time for reporting nuclear medicine results. Results should be reported within a time frame based on patient needs, services offered and the clinical personnel's needs. Emergency tests, after-hours and weekend testing needs should be included. The reports should be submitted timeously, in accordance with arrangements. When the hospital uses outside sources of nuclear medicine services, they should receive and review the quality control results of the outside source regularly. Qualified individuals should review the quality control results.

Patients are informed when the referring physician owns an outside source of radiology services.

Criteria

24.1.1.1 Adequate, convenient and regular nuclear medicine services are available to meet needs.

24.1.1.2 The selection of an outside source is based on an acceptable record and compliance with relevant laws and regulations.

24.1.1.3 Patients are informed about any relationships between the referring physician and outside sources of nuclear medicine services.

24.1.1.4 The nuclear medicine services provided meet applicable local and national standards, laws and regulations.

24.1.1.5 The hospital has established the expected turnaround time for reports within a time frame to meet patient needs.

24.1.1.6 Reports are clearly labelled with the name of the patient and the date and time of the procedures.

24.1.1.7 Quality control results from outside sources are regularly reviewed.

24.1.1.8 Qualified individuals review the quality control results.

24.2 Management of the service

24.2.1 *Where the hospital provides on-site nuclear medicine services, the service is organised and managed in accordance with applicable Namibian laws, regulations and standards.*

Standard Intent
Where the hospital provides an on-site service, suitably qualified and experienced managers ensure that the service is managed in accordance with applicable Namibian laws, regulations and standards.

Criteria

24.2.1.1 Nuclear medicine services are under the direction of one or more qualified individuals.

24.2.1.2 All professional personnel are currently registered.

24.2.1.3 There are qualified nuclear radiographers to provide services in keeping with the scope of their profession.

24.2.1.4 A qualified medical radiation physicist is available to fulfil the legal requirements of the regulations for the safe use of ionising radiation.

24.2.1.5 The services of a qualified radiopharmacist or nuclear medicine radiographer are available for radiopharmaceutical preparations.

24.2.1.6 Responsibilities include developing, implementing and maintaining policies and procedures.

24.2.1.7 The responsibilities of this person include administrative control.

24.2.1.8 The responsibilities of this person include maintaining quality control programmes.

24.2.1.9 The responsibilities of this person include monitoring and reviewing all nuclear medicine services.

24.3 Radiation safety

24.3.1 *A radiation safety programme is in place, followed and documented.*

Standard Intent
The hospital has an active radiation safety programme appropriate to the risks and hazards encountered. The programme addresses safety practices and prevention measures for nuclear medicine personnel, other personnel and patients. The programme is coordinated with the hospital's safety management programme.
The radiation safety programme includes:

- Documented policies and procedures which support compliance with applicable Namibian standards, laws and regulations

- Documented policies and procedures for the handling and disposal of infectious and hazardous materials
- The availability of safety protective devices appropriate to the practices and hazards encountered
- The orientation of all nuclear medicine personnel to safety procedures and practices
- In-service education for new procedures and newly-acquired or recognised hazardous materials

Criteria

24.3.1.1 A radiation safety programme is in place and is appropriate to the risks and hazards encountered.

24.3.1.2 The programme is coordinated with the hospitals safety management programme.

24.3.1.3 Personal dosimeters worn by personnel comply with the ionising radiation regulations.

24.3.1.4 Appropriate radiation safety devices are available.

24.3.1.5 Documented records of radioactive stocks, calculation and preparation, administration and disposal details are kept.

24.3.1.6 A register is kept of sealed sources.

24.3.1.7 Contamination monitors are provided.

24.3.1.8 Area monitors are available where necessary.

24.3.2 *There are documented policies and procedures to guide personnel in all aspects of the provision of nuclear medicine services.*

Standard Intent

Documented policies and procedures are essential to guide personnel in the nuclear medicine service in their activities. The existence of documented procedures does not preclude modifications in the best interests of the patient.

Nuclear medicine policies and procedures should be related to the requirements or availability of other services in the hospital environment.

Criteria

24.3.2.1 Documented policies and procedures that address compliance with applicable standards, laws and regulations are implemented.

24.3.2.2 The associated medical physicist is involved in the formulation of policies and radiation safety procedures applicable to nuclear medicine.

24.3.2.3 Policies and procedures that satisfy statutory requirements under the ionising radiation regulations are implemented.

24.3.2.4 A copy of the local rules relating to current ionising radiation regulations is available.

24.3.2.5 Policies and procedures that relate to limiting the irradiation of patients to levels consistent with medical requirements are implemented.

24.3.2.6 A strict policy on the conditions under which pregnant women may be subjected to a nuclear medicine examination is available and implemented.

24.3.2.7 There is a procedure to ensure professional handling of a radiation emergency.

24.3.2.8 Policies and procedures that relate to avoiding radioactive contamination, and controlling spread should it occur, are implemented.

24.3.2.9 A documented procedure is available for personnel to follow in the event of contamination.

24.3.2.10 Policies relating to monitoring the hands, clothing and body of every member of personnel leaving a controlled area are implemented.

24.3.2.11 Policies and procedures are implemented for the reporting of adverse reactions to therapy.

24.3.2.12 Policies and procedures are implemented for clinical trials, where applicable.

24.3.2.13 Policies and procedures that address the handling and disposal of infectious and hazardous materials are implemented.

24.3.2.14 Nuclear medicine personnel are oriented to safety procedures and practices.

24.3.2.15 Personnel receive education regarding new procedures and newly-acquired or recognised hazardous materials.

24.3.3 *All diagnostic equipment is regularly inspected and maintained, and appropriate records are kept of those activities.*

Standard Intent

Nuclear medicine personnel work with medical equipment management to ensure that all equipment and facilities function at acceptable levels and in a manner that is safe for the operator(s).

A nuclear medicine equipment management programme provides for:

- Selecting and acquiring equipment
- Identifying and taking an inventory of equipment
- Assessing equipment use through inspection, testing and maintenance
- Monitoring and acting on equipment hazard notices, recalls, reportable incidents, problems and failures
- Documenting the management programme

Testing and maintenance are related to the use of the equipment and its documented history of service.

Criteria

24.3.3.1 There is a nuclear medicine equipment management programme.

24.3.3.2 The programme includes selecting and acquiring equipment.

24.3.3.3 The programme includes taking an inventory of equipment.

24.3.3.4 The programme includes inspecting and testing the equipment.

24.3.3.5 The programme includes maintaining the equipment.

24.3.3.6 The programme includes monitoring and follow-up of the equipment.

24.3.3.7 Radiation monitors are calibrated regularly.

24.3.3.8 Values are recorded in a log-book.

24.3.3.9 The programme is implemented.

24.3.3.10 There is adequate documentation of all testing, maintenance and calibration of equipment.

24.3.4 *Facilities ensure the safe, efficient and effective functioning of the nuclear medicine service.*

Standard Intent
Nuclear medicine personnel work with management to ensure that facilities provide for safety and that they comply with current Namibian nuclear medicine laws and regulations.

Criteria

24.3.4.1 Facilities ensure that radiation to personnel is kept as low as possible.

24.3.4.2 At every entrance to a room where radioactive material is handled, a radiation warning sign is displayed.

24.3.4.3 Requirements laid down by the Department of Health regarding a controlled area are complied with.

24.3.4.4 A copy of the most recent radiation safety inspection report is held by the nuclear physician responsible for the department, or the medical physics department or the medical physicist.

24.3.4.5 There is a shower available in the event of contamination.

24.3.4.6 Separate toilets for personnel and patients are available.

24.3.4.7 Signs warning of the dangers of radiation to pregnant and breastfeeding women are prominently displayed.

24.3.5 *Radiopharmaceuticals intended for administration to patients are prepared in a manner which satisfies both radiation safety and pharmaceutical quality requirements.*

Standard Intent
Effective quality control systems are essential to providing excellent nuclear medicine services. Quality control procedures should include:

- Validation of the procedures used
- Daily surveillance of results by a nuclear medicine physician
- Rapid corrective action when a deficiency is identified
- Documentation of results and corrective actions

Criteria

24.3.5.1 Appropriate aseptic precautions are taken.

24.3.5.2 Regular and frequent gamma camera quality control procedures (e.g. flood uniformities, centre of rotation) are attended to or supervised by the medical physicist.

24.3.5.3 The radiopharmacy is designed to ensure that the history of each radiopharmaceutical dose can be traced.

24.3.5.4 Radiopharmaceuticals are only dispensed on written request.

24.3.5.5 All details of each Tc-99m generator are recorded, including full details of each elution.

24.3.5.6 Facilities are available for the quality control of all kits reconstituted on the premises.

24.3.5.7 There are separate facilities for the radiolabelling of blood products.

24.3.5.8 Blood products are labelled in a workstation with filtered air (at least a vertical laminar flow unit of biohazard type) to protect the product and designed to protect the operator against contamination.

24.3.5.9 All containers with radioactivity are labelled according to specifications stating that the contents are radioactive and indicating the activity and the date.

24.3.6 *The management of organ disease using open radionuclides is practised, considering the safety and well-being of patients and personnel as a consequence of the high radiation levels.*

Standard Intent

Where open radionuclides are used, all personnel and patients in the hospital must be protected from exposure to radiation by following established guidelines which are formulated by experts in the field. Supervision should ensure that the guidelines are adhered to.

Criteria

24.3.6.1 Where radioactive material administered to the patient exceeds a level of 370 MBq (10mCi), it is administered by the nuclear physician or radiation oncologist only.

24.3.6.2 Where radioactive material administered to the patient exceeds a level of 370 MBq (10mCi), there is an en-suite ward approved by the medical physicist for the isolation of the patient.

24.3.6.3 If the approved ward is not available, any alternative ward for the isolation of the patient receiving therapy is also approved by the medical physicist.

24.3.6.4 A radiation survey of the ward used for the isolation of the patient and adjacent areas is conducted according to the requirements of the physicist immediately after the administration of the radioactive material.

24.3.6.5 The isolated patient is monitored regularly during the isolation period.

24.3.6.6 On discharge of the patient who has been isolated, the ward, the bedding and the bathroom are monitored according to the requirements of the physicist.

24.3.6.7 Orally administered radioiodine is always in capsule form.

24.3.6.8 Radioiodine by injection (e.g. MIGB) is administered only by the nuclear physician or radiation oncologist.

24.3.6.9 A fume hood is used if liquid radioiodine is being prepared and the personnel preparing the radioiodine are adequately protected.

24.3.6.10 Administration of all radionuclides for therapy purposes is done in consultation with the physicist and according to statutory radiation safety norms.

24.4 Administration of tests

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

Standard Intent
The hospital must identify which nuclear medicine service personnel may assess patients and who may interpret and report on results. Personnel must have appropriate and adequate training, experience and skills and be oriented to their role. Work assignments allocated to personnel must be consistent with their training and experience. In addition, there should be sufficient personnel to perform procedures promptly and provide the necessary staffing levels during all hours of operation, including for emergencies.

Criteria

24.4.1.1 Examinations are performed only upon a formal request from a medical practitioner.

24.4.1.2 Nuclear medicine procedure requests contain all relevant clinical information.

24.4.1.3 If relevant radionuclides are available, all examinations are performed as soon as possible. Urgent scans are performed and reported on the same day.

24.4.1.4 Those individuals who perform testing and those who direct or supervise testing are identified.

24.4.1.5 Tests are interpreted by appropriately trained and experienced personnel.

24.4.1.6 Only a nuclear medicine physician or a registrar under supervision of a nuclear medicine physician or a radiologist may report on the results of nuclear medicine procedures.

24.4.1.7 An effective mechanism exists whereby emergency nuclear medicine procedure results are brought to the attention of the doctor who requested the examination.

24.4.1.8 Nuclear medicine procedure results are handled in a professional and confidential manner.

24.4.1.9 Reports are appropriately filed and distributed.

24.4.1.10 Mechanisms are in place to ensure the results of procedures can be retrieved when necessary.

24.5 Quality improvement

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

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). The senior management team ensures that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central/management/coordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.
The following will be evaluated:

- The manner in which problems were identified and prioritised in this service for which quality improvement activities were initiated
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, for example monitoring the checking of the emergency trolley over time, will be scored PC.

Criteria

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

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

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

24.5.1.4 A documentation audit system is in place.

24.6 Patient rights

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

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4).

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

Criteria

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

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

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

24.7 Prevention and control of infection

24.7.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

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

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

24.7.1.3 Infection control processes include safe injection practices, including single-use injection devices.

24.7.1.4 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

24.8 Risk management

24.8.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

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

24.8.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of interventions and responses to recorded incidents and interventions to prevent recurrence of the incident or minimize harm in the event of a recurrence.

24.8.1.3 Relevant personnel are trained in the procedures relating to the reporting and investigation of near misses/adverse events/sentinel events.

24.8.1.4 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

24.8.1.5 Fire safety measures are implemented.

24.8.1.6 The hospitals policy on handling, storing and disposing of healthcare waste is implemented.

25 Pharmaceutical Service

OVERVIEW OF PHARMACEUTICAL SERVICE

The hospital must ensure that appropriate medication is available and dispensed to meet the needs of patients. Appropriately qualified and experienced pharmacy personnel must ensure that the pharmaceutical service and medication use within the hospital comply with applicable Namibian laws and regulations and conform to professional best practice guidelines.

The prescribing, ordering, storage, preparation, dispensing and administration of medication should be guided by policies and procedures which are known to and implemented by hospital personnel. Qualified individuals within the hospital who are permitted to prescribe medication and those permitted to administer medication should be identified. Systems must be implemented to ensure that those who are not registered pharmacists are supervised and practise in accordance with current Namibian legislation.

Pharmacists should collaborate with all departments where medication is used and stored to develop and implement systems that ensure safe and consistent medication storage and utilisation practices throughout the hospital.

25.1 Management of the Service

25.1.1 *Medication use is organised throughout the hospital to meet the needs of patients.*

Standard Intent

As an important resource in patient care, medication use must be organised effectively and efficiently throughout the hospital. Medication management is not only the responsibility of the pharmaceutical service, but also of the managers and clinical care providers. How this responsibility is shared depends on the hospital's structure and staffing. In hospitals where there is no pharmacy, medication may be managed IN each clinical unit. In hospitals where there is a large central pharmacy, the pharmacy should organise and control medication throughout the hospital. Applicable laws and regulations must be incorporated into the organisational structure and the operations of the medication management system used in the hospital.

A registered pharmacist who is qualified by education, training and experience should be responsible for the direct supervision of the activities in the pharmacy or pharmaceutical service.

Documentation which guides the management of the service should be available and consulted, for example:

- Current Namibian acts and regulations relating to medication control
- Guidelines relating to professional practice, e.g. Joint FIP/WHO guidelines on good pharmacy practice: standards for quality of pharmacy services.

The pharmaceutical service should collaborate with all other departments in the hospital to ensure safe medication usage, and control and limit adverse drug reactions, drug-related adverse events and medication errors.
The forum for such collaboration can be provided by the Pharmaceutical and Therapeutics Committee, Medicine (Drug) Utilisation Committee and/or Therapeutic Drug Monitoring Committee. Minutes of these meetings should be circulated to all relevant departments.

Criteria

25.1.1.1 The pharmaceutical service is managed by a registered pharmacist with clearly defined responsibilities and accountability for all aspects of the service.

25.1.1.2 A registered pharmacist is designated as deputy to act in the absence of the manager.

25.1.1.3 The responsibilities of the pharmacy manager include ensuring compliance with laws and regulations relating to the service.

25.1.1.4 The responsibilities of the pharmacy manager include ensuring compliance with pharmacy practice and current pharmaceutical and other health professional guidelines, e.g. medical and nursing.

25.1.1.5 The pharmacy manager facilitates collaboration between pharmacy personnel and other relevant personnel in the hospital to ensure safe prescribing, ordering, storage, preparation, dispensing and administration of medications.

25.1.1.6 The manager ensures that reliable drug information is readily accessible.

25.2 Access to appropriate medication

25.2.1 *An appropriate selection of medication for prescribing or ordering is stocked or readily available.*

Standard Intent

Those responsible for managing and prescribing medication must decide which medication to make available. This decision should be based on the hospital's mission, patient needs and the types of services provided. The hospital should develop a list of all the medication it stocks or that are readily available from outside sources. In some cases, Namibian laws or regulations may determine the medication on the list or the source of those medications. Medication selection should be a collaborative process which considers patient needs and safety as well as financial factors. The hospital should have a method to maintain and monitor this medication list and to monitor the use of medication within the hospital, e.g. Pharmaceutical and Therapeutics Committee. Those who prescribe or order medication should know what medication is available and how to obtain it.

On occasion, medication not readily available to, or routinely stocked within, the hospital is required. There are also occasions where medication is needed at times when pharmacies are closed. Each hospital must plan for these occurrences and educate personnel on the procedures to follow should they occur. Pharmacists should be familiar with the indications for medication not routinely stocked within the hospital and where to obtain them when required.

When patient emergencies occur, quick access to appropriate emergency medication is critical. Each hospital must plan the location of emergency medication and the medication to be stocked in these locations. To ensure access to emergency medication when needed, the hospital must establish a procedure or process to prevent theft or loss of the medication and to ensure that medication is replaced when used, damaged or out of date.

Each hospital should define its role in providing medication to patients at discharge.

Occasionally, medication used routinely in the provision of services may not be available due to circumstances beyond the control of hospital management. In such cases, prescribers must be informed of the non-availability of such medication and advised of suitable available alternatives. Procedures

must be in place to locate and obtain stocks of the usual medication as soon as possible to minimise the disruption to services.

Criteria

25.2.1.1 Medication available for prescribing and ordering is appropriate for the hospital's mission, patient needs and services provided.

25.2.1.2 There is a list of medication stocked in the hospital or readily available from outside sources.

25.2.1.3 There is a method for control of medication use within the hospital.

25.2.1.4 There is a process to obtain required medication which is not routinely stocked or normally available to the hospital.

25.2.1.5 There is a process to obtain required medication when the pharmacy is closed.

25.2.1.6 Emergency medication is available in the hospital within a time frame to meet emergency needs.

25.2.1.7 Emergency medication is monitored and replaced in a timely manner, after use or when expired or damaged.

25.2.1.8 In the event of medication stock outs, prescribers are informed of the stock out and advised of suitable alternatives.

25.3 Policies and Procedures

25.3.1 *There is a collaborative process to develop and monitor policies and procedures for the pharmaceutical service.*

Standard Intent

Safe pharmaceutical practices should be guided by hospital policies and procedures. Medical, nursing, pharmacy and administrative personnel should participate in a collaborative process to develop the policies and procedures. The clinical and managerial leaders should use a collaborative process to train personnel in the content of these policies and procedures and monitor their implementation.

The policies or procedures should identify:

How planning will occur

a) The documentation required for the care team to work effectively, e.g. professional guidelines and legislation, order forms, communication forms, etc.,
b) Special consent considerations
c) Monitoring requirements
d) Special qualifications or skills of personnel involved in the care process
e) Availability and use of resuscitation medication

Clinical guidelines are helpful and may be incorporated in the process. Monitoring will provide the information required to ensure that the policies and procedures are adequately implemented for all relevant patients and services. Available policies and procedures should include the following as a minimum:

a) Safe ordering, storage, prescribing, dispensing and administration of medication in the hospital (prescription details should contain as a minimum two patient identifiers, name and formulation of

the drug, route, frequency and duration of administration, amount to be dispensed, date and name and signature of the prescriber)
b) How to manage illegible prescriptions, including the reduction and elimination of illegible prescriptions
c) Use of verbal medication orders
d) Availability and use of medication samples
e) Documentation and management of any medication brought into the hospital for or by the patient
f) Self-administration of medication by the patient
g) Dispensing of medication at the time of the patient's discharge
h) Pre-packing and labelling of medication
i) Preparation, handling, storage and distribution of parenteral and enteral nutrition products
j) Location, labelling, storage, handling, distribution and dispensing of controlled, high-alert and hazardous medication (e.g. insulin, chemotherapy drugs, heparin, etc.)
k) Storage, handling, distribution and dispensing of look-alike, sound-alike medication
l) Storage, handling, distribution and dispensing of investigational medication including radioactive compounds
m) Labelling of medication administered via intravenous infusion must include the patient name, drug, dose, rate of infusion, signature of the person who prepared the infusion, date and time of initiation of infusion and anticipated date and time of completion of infusion.
n) Management of medication used in clinical trials.
o) Security of personnel, equipment and stock
p) Adverse drug reactions (ADR)
q) Drug-related adverse events
r) Medication errors
s) Medication recall
t) Destruction of expired or outdated medication and related products

Please note that it is not necessary to have a separate policy to cover each of the areas listed above – several areas may be covered adequately and appropriately in a single policy.

Criteria

25.3.1.1 Policies and procedures, which include (a)–(t) in the standard intent above as a minimum, are developed and implemented.

25.3.1.2 There is evidence that policies and procedures have been developed collaboratively with all relevant departments.

25.4 Dispensing

25.4.1 *Medication is dispensed in accordance with legislation, regulations and professional standards of practice.*

Standard Intent

A registered pharmacist must review each prescription or order for medication. When queries arise, the individual who prescribed or ordered the medication must be contacted. The dispenser must sign the prescription. When pharmacist assistants, technicians or interns dispense, they must be supervised and their signatures to confirm dispensing must be countersigned by a registered pharmacist.

The hospital must dispense medication in the most ready-to-administer form possible to minimise opportunities for error during distribution and administration. The central pharmacy and other medication distribution points throughout the hospital (including related facilities such as satellite clinics,

etc.) must all use the same dispensing system. The system must support accurate dispensing of medication in a timely manner.

It is generally accepted that the dispensing process is divided into three phases:
Phase 1: Interpretation and evaluation of a prescription
Phase 2: Preparation and labelling of the prescribed medication
Phase 3: Provision of information and instructions to the patient to ensure the optimum use of medication

Criteria

25.4.1.1 Medication is prepared and dispensed in a safe and clean environment.

25.4.1.2 There is a uniform medication dispensing and distribution system throughout the hospital.

25.4.1.3 The system supports accurate and timely dispensing.

25.4.1.4 Medication is securely and legibly labelled with relevant information as required by hospital policy.

25.4.1.5 Where computer programs are used to check for contra-indications and potential drug interactions for prescribed medication, there is a process to ensure that the program is current and updated according to the manufacturer's recommendations.

25.5 Control and Storage of Medication

25.5.1 *Medication is stored in a secure and clean environment.*

Standard Intent
Secure storage systems ensure that pharmaceuticals and related substances are held under conditions which conform to statutory and manufacturer's requirements. Arrangements should be in place to ensure the security of medicines, including alarm systems, door access controls and safes/vaults used to store controlled medicines.

The pharmacy or pharmaceutical services store must dispense medication in a clean and secure environment, which complies with legislation, regulations and professional practice standards. In particular, medication must be clearly labelled, stored correctly and in an orderly fashion and protected from heat, light and moisture to maintain product stability when necessary.

Deep freeze, refrigeration, cold room and cool area facilities must be provided for safe storage of medication that requires these conditions. There must be a mechanism in place to ensure that the temperature has been maintained throughout the life of the medication. Deep freezers and refrigerators must be defrosted when necessary. Doors, hinges and seals must all be functional.

Medication stored and dispensed from areas outside the pharmacy, for example patient care units, should comply with the same safety measures, including labelling requirements for pre-packed medications. There must be a registry, log or other mechanism to monitor and account for controlled substances.

Criteria

25.5.1.1 Separate designated storage areas for the receipt and unpacking of incoming goods are provided.

25.5.1.2 Hazardous and flammable materials are stored in accordance with relevant regulations.

25.5.1.3 Separate designated storage areas for materials under quarantine are provided.

25.5.1.4 Safe and secure storage facilities are available, including smoke detectors, security alarm systems and/or barriers.

25.5.1.5 Stock control systems are managed in the pharmacy and other related departments.

25.5.1.6 A management information system is available, which provides accurate statistics relating to pharmaceutical receipts and issues.

25.5.1.7 Medication is stored in a clean environment.

25.5.1.8 The cold chain is maintained for medication where necessary.

25.5.1.9 Medication storage areas are protected from heat, light and moisture and temperatures are monitored and recorded.

25.5.1.10 Appropriate action is taken when temperatures are higher or lower than recommended limits.

25.5.1.11 Medication identified for special control by law or hospital policy are stored in a cabinet of substantial construction, for which only authorised personnel have a key.

25.5.1.12 Medication identified for special control by law or hospital policy are accurately accounted for.

25.6 Quality Improvement

25.6.1 *A formalised proactive quality improvement approach is maintained in the service.*

Standard Intent

This refers to the implementation of hospital quality improvement processes (Service Element 7). It is the responsibility of the management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) Completion of prescriptions
b) The use of antibiotics and other medication
c) Medication errors
d) Adverse medication effects
e) Patient and family expectations and satisfaction
f) Audits of medication storage/use in the departments
g) Monitoring of financial aspects

h) Out-of-stock items, aged items
i) Analysis of complaints, negative incidents, patient satisfaction
j) Monitoring of illegible scripts

The following will be evaluated:
- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems - Identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed results, where appropriate

A once-off project, for example, supplying a thermometer for a refrigerator, will be scored as NC.

Criteria

25.6.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

25.6.1.2 Indicators of performance are identified to evaluate the quality of the service.

25.6.1.3 The pharmacy has a system in place to monitor the appropriate use of antibiotics within the hospital.

25.6.1.4 Data relating to medication errors and adverse drug reactions is used to improve medication management within the hospital and monitor the effectiveness of actions taken to prevent recurrence of such events.

25.6.1.5 The quality improvement cycle includes the monitoring and evaluation of the standards set and the remedial action implemented.

25.6.1.6 A documentation audit system is in place.

25.7 Patient Rights

25.7.1 *The service implements processes that support patient and family rights during care.*

Standard Intent

This refers to the implementation of hospital policies on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

25.7.1.1 There are processes that support patient and family rights during care.

25.7.1.2 Measures are taken to protect the patient's privacy and person.

25.7.1.3 Personnel respect the rights of patients and families to treatment and to refuse treatment.

25.8 Prevention and Control of Infection

25.8.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

25.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

25.8.1.2 Infection control processes include prevention of infection while undertaking sterile procedures.

25.8.1.3 Infection control processes include prevention of infection during the process of preparation and dispensing of medication.

25.8.1.4 Infection control processes include prevention of water contamination during the preparation of suspensions/liquid medications.

25.9 Risk Management

25.9.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

25.9.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

25.9.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of interventions and responses to recorded incidents.

25.9.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

25.9.1.4 Fire safety measures are implemented.

25.9.1.5 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

26 Therapeutic Support Services

OVERVIEW OF THERAPEUTIC SUPPORT SERVICES

This service element applies to the following services:

- Physiotherapy
- Occupational therapy
- Therapeutic nutritional services
- Audiology
- Speech therapy
- Clinical psychology
- Social work
- Orthotics

A hospital's main purpose is patient care. Providing the most appropriate care in a manner that supports and responds to the unique needs of each patient and family requires a high level of planning and coordination.

Certain activities form the basis of all patient care. These include:

- The assessment of patients
- The planning and delivery of care
- Monitoring and evaluating the results of care provided for each patient
- Adapting and implementing care plans according to the patient's changing needs
- Appropriate follow up arrangements effectively communicated to the patient and their carers

Many medical, nursing, pharmaceutical, rehabilitation and other types of healthcare providers may carry out these activities. Each provider should have a clear role in patient care. Credentials, registration, law and regulation, an individual's particular skills, knowledge and experience and hospital policies or job descriptions determine that role. The patient, the family or trained caregivers may carry out some of this care.

Providing the most appropriate care that supports and responds to the unique needs of each patient and family requires a high level of planning and coordination. Comprehensive care and support is dependent upon an interdisciplinary approach, which is strengthened by access to a broader multidisciplinary team. This team can include audiologists, clinical psychologists, dieticians, occupational therapists, physiotherapists, social workers and speech therapists.

A plan for each patient should be based on an assessment of needs. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is coordinated, integrated and monitored. The efficient functioning of multidisciplinary cooperation is particularly important where physical rehabilitation services are provided. Rehabilitation centres may be affiliated to other healthcare facilities such as hospitals or may be separate, free-standing facilities. These centres provide comprehensive physical rehabilitation for a number of conditions, which can include spinal cord injuries, traumatic brain injuries, cerebro-vascular accidents (stroke), trauma, amputations, joint replacements, burns, etc.

Rehabilitation programmes aim to provide optimal recovery based on achievable and measurable outcomes. The goal is to assist individuals to achieve as much independence in activities of daily living as possible. This requires an interdisciplinary approach, where a group of therapists offer a range of services. This enables coordination of therapies among all role-players to the advantage of the patient. Patients may be treated on an in-patient or out-patient basis.

Establishing goal-orientated rehabilitation in a traditional hospital setting can be very difficult. One of the two models below may be used, or they may be combined:

1. Multi-disciplinary teams consist of various professionals treating the patient separately, usually with discipline-specific goals. Patient progress with regard to each discipline is communicated through documentation or at meetings for information exchange.
2. In the interdisciplinary model, each professional evaluates the patient and then interacts with the other professionals involved at team meetings where assessments are shared and goals are

established. A unique rehabilitation plan is then developed. When this approach is used, the result is greater than just the total of the various components.

Rehabilitation has been defined as the development of a person to his or her fullest physical, psychological, social, vocational and educational potential, consistent with his or her impairment and the environmental limitations.

It usually requires five sub-components:

- A unique patient-centred plan, formulated by the patient and the rehabilitation team
- The establishment of achievable goals
- Patient participation to reach those goals
- The person reaching his/her potential
- The measurement or demonstration of outcomes achieved

This service element is designed to enable personnel in the various services to assess, monitor and improve the quality of care in their own service. Managers of the services should work with other hospital leaders and managers to improve the quality of care throughout the hospital and should comply with the criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

26.1 Management of the Therapeutic Support Services

26.1.1 *Each service is managed to ensure the provision of a safe and effective service.*

Standard Intent
Departmental and service managers are primarily responsible for ensuring that the mission of the hospital is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each personnel member in the department must be defined in writing; each one must sign their own document to show that they are in agreement with their job description. Documents should be prepared by each department which define its goals, as well as identify current and planned services. Lines of communication within each department should be documented to ensure clear accountability.

Criteria

26.1.1.1 A designated individual is responsible for each service.

26.1.1.2 The service manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

26.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

26.1.1.4 The responsibilities of the manager and personnel are defined in writing.

26.2 Multi/Interdisciplinary approach

26.2.1 *Policies and procedures guide the activities of the multi/interdisciplinary team.*

Standard Intent
Hospital and departmental policies and procedures are essential. They provide personnel with the guidance required to perform their tasks. It is important that there is a system in place to ensure that

policies and procedures are known, understood and implemented. They should be available, indexed, signed, dated and authorised by the hospital leaders. Outdated policies and procedures should be recalled and archived according to hospital policy to prevent the accidental implementation of outdated practices.
Policies and procedures should focus on patients and procedures, e.g.

Referral systems
- Assessment methods
- Treatment protocols
- Rehabilitation techniques and equipment

Criteria

26.2.1.1 Policies and procedures are signed by persons authorised to do so.

26.2.1.2 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel.

26.2.1.3 Each policy and procedure is reviewed according to hospital policy.

26.2.2 *Clinical practice guidelines are used to guide patient care and reduce undesirable variation.*

Standard Intent
Professional personnel have a responsibility to ensure that they are employing up-to-date methods for diagnosis and management, which are broadly consistent with those of other practitioners of the same profession.

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions.

Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice and/or care pathways. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by hospital leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the catchment population, patient needs and hospital resources. Once implemented, guidelines should be reviewed on a regular basis to ensure their continued relevance.

Criteria

26.2.2.1 Evidence-based clinical practice guidelines relevant to the patients and services of the hospital are available to guide patient care processes.

26.2.2.2 The implementation of guidelines is monitored as part of a structured clinical audit.

26.2.2.3 Guidelines are reviewed and adapted on a regular basis.

26.3 Facilities and equipment

26.3.1 *Resources are available to meet the treatment needs of the population served.*

Standard Intent

In order to meet the needs of the catchment population, each unit requires adequate resources. Departmental managers need to work closely with hospital managers to ensure that facilities and equipment provided are adequate to deliver the services and achieve the desired outcomes for patients accessing these services. Departmental managers should keep hospital managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

Criteria

26.3.1.1 Each service has adequate space to treat patients effectively.

26.3.1.2 There is adequate space for the storage of equipment and materials.

26.3.1.3 Privacy is ensured through private cubicles, curtains or screens.

26.3.1.4 There is an emergency call system for summoning of medical assistance.

26.3.1.5 The audiology service has relevant equipment and materials to provide an effective service.

26.3.1.6 The clinical psychology service has relevant equipment and materials to provide an effective service.

26.3.1.7 The occupational therapy service has relevant equipment and materials to provide an effective service.

26.3.1.8 The physiotherapy service has relevant equipment and materials to provide an effective service.

26.3.1.9 The social work service has relevant equipment and materials to provide an effective service.

26.3.1.10 The speech therapy service has relevant equipment and materials to provide an effective service.

26.3.1.11 The prosthetics and orthotics service has relevant equipment and materials to provide an effective service.

26.3.1.12 The manager of each department ensures that equipment is included in the hospital's maintenance programme.

26.4 Patient care

26.4.1 *All patients treated by the multi/interdisciplinary team have their healthcare needs identified through an established assessment process.*

Standard Intent

The hospital defines in writing the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable Namibian laws and regulations. These findings are used throughout the care process to evaluate a patient's progress and understand the need for reassessment. It is essential that assessments are documented well and can be easily retrieved from the patient's record.

The hospital determines the time frame for completing assessments. This may vary in the different settings within the hospital. When an assessment is partially or entirely completed outside the hospital, the findings must be verified on admission to the relevant therapeutic support service.

Criteria

26.4.1.1 The hospital implements policies and procedures for assessing patients referred to therapeutic support services.

26.4.1.2 The scope and content of assessment by each discipline is defined.

26.4.1.3 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

26.4.1.4 Assessments are performed within appropriate time frames and adequately documented in the patient's records according to hospital policy.

26.4.1.5 Assessments completed entirely outside the hospital are verified on admission to the service.

26.4.2 *The delivery of services is integrated and coordinated amongst care providers.*

Standard Intent

A patient benefits most when the personnel responsible for the patient work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established and care decisions are made.

The coordination of patient care depends on the exchange of information between the multi/interdisciplinary team members. This can be through verbal, written or electronic means according to appropriate policies determined by the hospital. Clinical leaders should use techniques to improve the integration and coordination of care for their patients, e.g. team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records and case managers. The process for working together will be simple and informal when the patient's needs are not complex.

The individuals who bear overall responsibility for the patient's care or for a particular phase of care must be identified in a manner that is made known to the patient and to other members of the multi/interdisciplinary team. The patient, family and others should be included in the decision process when appropriate.

The patient's record must contain a history of all care provided by the multidisciplinary team and should be made available to all relevant caregivers who are authorised to access its content.

Criteria

26.4.2.1 Assessment findings are documented in the patient's record and are readily available to those responsible for the patient's care.

26.4.2.2 Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

26.4.2.3 Patient needs are prioritised on the basis of assessment results.

26.4.2.4 There is a multidisciplinary approach to the development and implementation of a therapeutic programme in accordance with a policy framework.

26.4.2.5 The team consists of appropriately qualified personnel and includes representatives from all services offering care to the patient.

26.4.2.6 Each patient's care is coordinated by a designated individual who is appointed by the team and made known to the patient.

26.4.2.7 The team members' responsibilities include development and implementation of care plans for each patient, based on the assessment of the patient.

26.4.2.8 The team conducts periodic re-evaluation of each patient's plan of care to determine whether established goals are being or have been met and whether change in the patient's condition requires modification of goals.

26.4.2.9 The team includes the patient and his/her family in the development and review of the plan of care, as appropriate.

26.4.3 *The care provided to each patient is planned and written in the patient's record.*

Standard Intent
Adequate patient records are essential for maintaining continuity of care, professional development and medico-legal protection.

Criteria

26.4.3.1 The care provided to each patient is planned and documented in the patient's record.

26.4.3.2 All procedures and diagnostic tests ordered and performed are documented in the patient's record.

26.4.3.3 The results of procedures and diagnostic tests performed are available in the patient's record.

26.4.3.4 Reassessments are documented in the patient's record.

26.4.3.5 The patient's plan of care is modified when the patient's needs change.

26.5 Patient and family education

26.5.1 *Education supports patient and family participation in care decisions and care processes.*

Standard Intent
Every patient should be offered the information and education required to be an active participant in maintaining their own health and well-being, appropriate to their current health status. Hospitals may choose to appoint an education coordinator, an education committee or service, or simply work with all personnel to provide education in a coordinated manner.

Criteria

26.5.1.1 Patients and families indicate that they have been informed about participation in the care process.

26.5.1.2 Patients indicate that they have been informed about the management of their condition.

26.5.1.3 Patients and families indicate that they have been informed about any financial implications of care decisions.

26.5.1.4 When appropriate, patients and families indicate that they have been educated about the use of rehabilitation techniques and/or equipment.

26.6 Quality improvement

26.6.1 *A formalised proactive quality improvement approach is maintained in the service.*

Standard Intent

This refers to the implementation of hospital quality improvement processes (Service Element 7). It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality management structures or systems. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

- Patient assessment
- The success of therapeutic interventions carried out
- The availability, contents and use of patient records
- Patient and family expectations and satisfaction

The following will be evaluated:

- The manner in which problems were identified and prioritised in each service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- Identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC. Quality improvement processes not related to the clinical quality of patient care but to the environment within which care is provided, for example monitoring the cleaning of equipment over time, will be scored PC.

Criteria

26.6.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

26.6.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

26.6.1.3 The quality improvement cycle includes the monitoring and evaluation of the standards set and the remedial action implemented.

26.6.1.4 A documentation audit system is in place.

26.7 Patient rights

26.7.1 *The department/service implements processes that support patient and family rights during care.*

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

26.7.1.1 There are processes that support patient and family rights during care.

26.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

26.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

26.8 Prevention and control of infection

26.8.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

26.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

26.8.1.2 Infection control processes include prevention of the spread of respiratory tract infections.

26.8.1.3 Infection control processes include prevention of the spread of infection through use of medical and rehabilitation equipment.

26.9 Risk management

26.9.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

26.9.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

26.9.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of responses to recorded incidents and interventions to prevent recurrence of the incident or minimise harm in the event of a recurrence.

26.9.1.3 Security measures are implemented to ensure the safety of patients, personnel and visitors.

26.9.1.4 Fire safety measures are implemented.

26.9.1.5 The hospital's policy on handling, storage and disposal of healthcare waste is implemented.

27 Central Sterile Supplies Department

OVERVIEW OF CENTRAL STERILE SUPPLIES DEPARTMENT

The central sterile supplies department (CSSD) performs an integral function in hospitals. Medical devices, instruments, equipment and consumables are sterilised and/or disinfected for use by personnel in the operating theatre and other departments.

The department must be designed as a "one-way" system to allow for the receipt and cleaning of previously used or unsterile items, the checking and packing thereof before sterilisation and the distribution of disinfected and sterilised items. In many cases the CSSD is attached to the operating theatre suite, but it may also stand alone or be a combination of both systems.

This Service Element is designed to enable personnel in the particular service to assess, monitor and improve the quality of care in their own service.
The manager of the service should work with other hospital leaders and managers to improve the quality of care throughout the hospital and ensure that the unit complies with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement. This Service Element therefore strengthens the standards in previous Service Elements, but cannot be used in isolation

Please note: the unit will be referred to as CSSD throughout. However, hospitals may refer to the unit using various names such as sterilising and disinfecting units, theatre sterilising department, or another name. Whatever the name used by the hospital, this Service Element relates to the service that is responsible for the sterilising and disinfecting of hospital equipment and supplies.

Standards

27.1 Management of the Service

27.1.1 *CSSD is managed to ensure the provision of a safe and effective service.*

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the hospital is met through the provision of management and leadership at departmental level. Good departmental or service performance requires clear leadership from a suitably qualified individual. The responsibilities of each role in the department should be defined in writing. Documents should be prepared by each department to define its goals and identify current services. Lines of communication within each department should be documented.

Often the person in charge of the operating theatre assumes responsibility for the CSSD as well. Where the unit is physically separated from the theatre suite, this may not be possible and another person may assume this function.

The person in charge of the unit should preferably be a professional nurse or qualified CSSD manager, who can liaise with surgeons and other operating theatre personnel regarding their needs. This person should have knowledge of infection control processes and sterilising methods.

Policies and procedures are essential to ensure that personnel receive guidance in the execution of functions for which they are responsible. Departmental policies may be standardised for similar functions executed in several departments, or unique to the particular department. They must be available, indexed, signed, dated and authorised by the hospital leaders. Outdated policies and procedures should be recalled and archived according to hospital policy to prevent the accidental implementation of outdated practices. A system must be in place to ensure that departmental policies

and procedures are known and implemented. Monitoring should provide the information required to ensure that the policies and procedures are implemented for all relevant services.

Of particular concern is that the policies or procedures identify:

- How planning will occur
- The documentation required for the care team to work effectively
- Special considerations
- Monitoring requirements
- Special qualifications or skills of personnel

Policies and procedures should cover at least:

a) Processes for cleaning sterilising equipment
b) Ordering of sterile supplies from suppliers
c) Receiving, checking and packing supplies received from the suppliers
d) Storage of sterile supplies
e) Procedures in the decontamination and sterilisation process
f) Recording of issues of stock and maintaining stock levels
g) Ensuring that supplies are kept sterile
h) Management of incidents where the sterility of supplies has not been maintained
i) Provision of emergency and after-hours sterile supply/sterilisation services
j) Safe use of sterilising equipment
k) Sterilisation of liquids
l) Use of ethylene oxide
m) Use of low temperature sterilisation
n) Validation of equipment

Maintenance of equipment

Criteria

27.1.1.1 A designated individual is responsible for the sterilising and disinfecting service.

27.1.1.2 The manager ensures that policies and procedures, which include items (a)-(o) in the standard intent above as a minimum, are available to guide personnel in the service and that they are implemented.

27.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

27.1.1.4 The responsibilities of the unit manager are defined in writing.

27.2 Facilities and Equipment

27.2.1 *The unit is designed to allow for effective decontamination and sterilisation of medical equipment and supplies.*

Standard Intent

It is essential that the physical space of the unit is utilised to ensure that the flow of work progresses from the soiled to the clean side of the unit with separation of dirty and clean/sterile areas. This should include a dedicated area for the cleaning of equipment and instruments. With careful planning, this can be achieved even in a small, one-room unit.

Formal communication pathways should be established to ensure that departmental managers keep the senior hospital management team informed regarding the current state of facilities and equipment

and make known the additional requirements needed for the provision of an adequate sterilising and disinfecting service for the hospital.

Criteria

27.2.1.1 The design of the sterilising and disinfecting unit and the layout of equipment ensure the flow of work from the soiled to the clean side of the unit.

27.2.1.2 There is a washing and decontamination area, with clean running water and a sink connected to the sewage system.

27.2.1.3 There is a pre-packing area with storage facilities for clean materials.

27.2.1.4 The autoclave area is equipped with loading and unloading trolleys at the correct height.

27.2.1.5 There is a storage area for sterile packs with racks which allow for an adequate circulation of air.

27.2.1.6 Adequate light and ventilation are available.

27.2.2 *Effective sterilising equipment is available.*

Standard Intent

There are many methods of sterilising equipment. Whatever methods are used, personnel should ensure that the equipment used is effective. Systems must therefore be in place to confirm that sterility is obtained through the sterilisation processes.

Criteria

27.2.2.1 There are one or more autoclaves or their equivalent capable of sterilising porous loads (gowns, drapes and dressings), as well as wrapped and unwrapped instruments.

27.2.2.2 Autoclaves/sterilising units are appropriate to their use and comply with licensing requirements.

27.2.2.3 Where liquids are sterilised, an autoclave with a fluid cycle and a reverse osmosis or distillation plant are also provided.

27.2.2.4 Where ethylene oxide is used as a sterilising agent, the installation complies with relevant safety standards and legislation.

27.2.2.5 The sterilising ability of each autoclave is tested daily and the results recorded in a log book.

27.2.2.6 The sterility of each pack is shown on indicator tapes, which are suited to the processes used.

27.2.2.7 Any incidents of failure of sterilisation procedures are recorded and investigated.

27.2.2.8 Sterilising and disinfecting unit personnel ensure that all equipment is included in the hospital's equipment replacement and maintenance programme.

27.2.3 *The sterility of equipment and supplies is maintained.*

Standard Intent
Once sterility has been achieved, it is possible that sterility may be breached in the storage, issue or distribution of sterile supplies. Systems must be in place to ensure that packs reach the user sterile and intact.

Criteria

27.2.3.1 There is a mechanism to ensure that sterile supplies are dated and used on a "first expired first out" basis.

27.2.3.2 The maintenance of sterility is checked before any sterile packs are issued.

27.2.3.3 There is a system for the ordering, storage, maintenance and distribution of sterile supplies.

27.3 Quality Improvement

27.3.1 *A formalised proactive quality improvement approach is maintained in the service.*

Criteria

27.3.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

27.3.1.2 Indicators of performance are identified to evaluate the quality of the service.

27.3.1.3 The quality improvement cycle includes the monitoring and evaluation of the standards set, and the remedial action implemented.

27.4 Prevention and Control of Infection

27.4.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

27.4.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

27.4.1.2 Infection control processes include prevention of infection from contaminated instruments.

27.5 Risk Management

27.5.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

27.5.1.1 The department conducts on-going monitoring of risks through documented assessments as part of hospital risk management processes.

27.5.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of interventions and responses to recorded incidents.

27.5.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

27.5.1.4 Fire safety measures are implemented.

27.5.1.5 Hospital policy on handling, storage and disposal of healthcare waste is implemented.

28 Food and Therapeutic Nutritional Services

OVERVIEW OF FOOD AND THERAPEUTIC NUTRITIONAL SERVICES

A hospital's main purpose is patient care. Providing the most appropriate care in a manner that supports and responds to the unique needs of each patient and family requires a high level of planning and coordination. The nutritional status and needs of patients form an integral part of the care planning process.

Certain activities form the basis of all patient care. These include:

- The assessment, planning and delivery of care
- Monitoring and evaluating the results of the care provided for each patient
- Adapting and implementing care plans according to the patient's changing needs

A care plan is not sufficient to achieve optimal outcomes unless the delivery of services is coordinated and monitored. Therefore, hospital services and departments need to consider the care they provide as part of an integrated system of services. Throughout all phases of care, patient needs should be matched with appropriate resources.

This Service Element is designed to enable personnel in the food and therapeutic nutritional services to assess, monitor and improve quality in their own services. The managers of the services must work with other hospital leaders and managers to improve the quality of care throughout the hospital and ensure that the food and therapeutic nutritional services comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement. This Service Element therefore strengthens the standards in previous Service Elements but cannot be used in isolation.

Standards

28.1 Management of the service

28.1.1 *The food service is managed to ensure the provision of a safe and effective service.*

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the hospital is met through the provision of management and leadership at departmental level. Good departmental or service performance requires clear leadership from a suitably qualified individual.
The responsibilities of each member of personnel in the department should be defined in writing.
Each one should sign their own document to show that they are in agreement with their job description.Documents should be prepared by each department that define its goals and identify both current and planned services.Lines of communication within each department should be documented to ensure clear accountability.

Departmental policies and procedures are essential. They provide personnel with the guidance required to carry out the functions of the department. It is therefore important to have a system in place to ensure that departmental policies and procedures are known, understood and implemented.
Policies must be available, indexed, signed, dated and authorised by the hospital leaders.

Criteria

28.1.1.1 A designated individual is responsible for the food service.

28.1.1.2 The food service manager ensures that policies and procedures are available to guide personnel and that they are implemented.

28.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

28.1.1.4 The responsibilities of the unit manager are defined in writing.

28.2 Facilities and equipment

28.2.1 *The kitchen is designed to allow for hygienic food management.*

Standard Intent
Departmental managers need to work closely with hospital managers to ensure that facilities and equipment are adequate. Departmental managers should keep hospital managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

The food service must comply with all Namibian legislation and regulations relevant to the service. Such regulations may include building regulations, occupational health and safety legislation and regulations regarding the handling and preparation of food in a commercial capacity.
Copies of relevant acts and regulations should be available in the food service premises for reference purposes, either in electronic or paper format.

Criteria

28.2.1.1 The food service area meets with health and safety regulations.

28.2.1.2 There are separate hand washing facilities in the food preparation area, with soap and paper towels.

28.2.1.3 The temperature, ventilation and humidity levels are controlled and monitored to ensure satisfactory working conditions and cleanliness.

28.2.1.4 There is an effective method of fly control.

28.2.1.5 There is adequate lighting and ventilation, including in the storage areas.

28.2.1.6 Refrigerators and freezers can be opened from the inside using a safety release mechanism.

28.2.2 *The food service premises are designed to provide facilities for food handlers.*

Criteria

28.2.2.1 Lockers are provided for food handlers, which can accommodate their outer clothing.

28.2.2.2 There are adequate, suitable and conveniently placed change rooms, toilets and ablution facilities for food handlers.

28.2.2.3 Ablution and change facilities are well lit and well ventilated.

28.2.2.4 Ablution facilities are kept clean.

28.2.2.5 Adequate numbers of suitable refuse containers are provided in or near each change room, hand washing and toilet area.

28.2.3 *The therapeutic nutritional service has adequate facilities and equipment to meet the treatment needs of the population served.*

Standard Intent
Departmental managers need to work closely with hospital managers to ensure that facilities and equipment are adequate. Departmental managers must keep hospital managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

Criteria
28.1.1.1 There is adequate space for dieticians/nutritionists to treat patients effectively.

28.2.3.1 Adequate and relevant equipment and materials are available to provide an effective service.

28.2.3.2 There is adequate space for the storage of equipment and materials.

28.2.3.3 Privacy is ensured through private cubicles, curtains or screens.

28.3 Policies and procedures

28.3.1 *Policies and procedures guide the management of the service.*

Standard Intent
Departmental policies and procedures provide guidance to personnel in carrying out their functions within the department. It is therefore important to have a system in place to ensure that departmental policies and procedures are known, understood and implemented. They need to be available, indexed, signed, dated and authorised by the hospital leaders.Outdated policies and procedures should be recalled and archived according to hospital policy to prevent the accidental implementation of outdated practices.
It is particularly important that the policies or procedures indicate:

- How planning will occur
- The documentation required
- Special considerations
- Monitoring requirements
- Special qualifications or personnel skills

Policies and procedures for the food service must address the following as a minimum:
a) Wearing jewellery on wrists and hands
b) Wearing nail polish and artificial nails while preparing food
c) Hand washing procedures
d) Food preparation procedures and routines
e) Cleaning food preparation areas and equipment
f) Disposing of kitchen waste
g) Safe work procedures

Procedures to be followed if food handlers or those living with them (i.e. family members or housemates) develop diarrhoea, vomiting, throat infections, skin rashes, boils or other skin lesions, eye or ear infections
In particular, when food handlers, their family members or housemates develop any of the conditions listed in (h) above, there must be a system in place to ensure that these illnesses are reported, and adequate precautions taken to ensure that these conditions are not transmitted to other food workers or individuals consuming the food prepared in the kitchen.The system should be designed in collaboration with the infection control team or equivalent in the hospital, in accordance with best practice guidelines.It may also be necessary to involve those responsible for occupational health services within the hospital

Policies and procedures for the therapeutic nutritional service should focus on patients and procedures, e.g.:
a) Consultation and referral systems
b) Special dietary requirements
c) Menu planning
d) The provision of nutritional supplements

Criteria

28.3.1.1 The departmental manager ensures the availability and implementation of policies and procedures, which include (a)-(h) in the standard intent above as a minimum for the food service and (a)–(d) for the therapeutic nutritional service.

28.3.1.2 There is a system in place to ensure that food handlers report conditions that may result in the transmission of infection to other food handlers or to individuals consuming food prepared in the kitchen and appropriate action is taken to prevent transmission.

28.3.1.3 Policies and procedures are signed by persons authorised to do so.

28.3.1.4 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel.

28.3.1.5 Each policy and procedure is reviewed according to hospital policy.

28.3.1.6 Outdated policies and procedures are recalled and archived according to hospital/organisational policy.

28.4 Menu planning

28.4.1 *Menus are planned, and meals are prepared to meet patient needs. Intent of 28.4.1*

Standard Intent
Menus may be planned by an outsourced organisation, a dietician employed by the hospital, or other individuals with acceptable food management qualifications and suitable experience.It is important that specific patient needs are catered for, including cultural needs.

Criteria

28.4.1.1 A suitably qualified person advises on meal development.

28.4.1.2 There is a planned weekly menu, suitable for different seasons.

28.4.1.3 Patients are provided with at least three meals per day.

28.4.1.4 Wherever possible, patient food preferences are respected, and substitutions made available.

28.4.1.5 Cultural preferences are taken into account.

28.4.1.6 The nutritional needs of patients without teeth and geriatric patients are considered.

28.4.1.7 There are no more than 14 hours between the evening meal and the next substantial meal.

28.5 Maintenance of food hygiene

28.5.1 *Food handlers maintain a hygienic food preparation environment.*

Standard Intent
Foods must be stored and prepared in accordance with documented protocols developed by suitably qualified and experienced personnel who also control the receipt, storage and preparation of foods. High risk foods, which may be contaminated, and which may contaminate other foods, must be stored separately. This includes such foods as meat, poultry and fish.

Criteria

28.5.1.1 Food handlers wear appropriate protective clothing.

28.5.1.2 There is a mechanism to prevent unauthorised individuals from entering food preparation areas.

28.5.1.3 Persons not normally employed in the food service wear protective clothing while in the area.

28.5.1.4 Preparation surfaces are cleaned and dried between use for different activities.

28.5.1.5 Separate cutting boards are kept for raw and cooked food as well as different types of food, e.g. vegetables, meat, fish.

28.5.1.6 Floors, walls and ceilings are clean.

28.5.2 *Food products and meals are hygienically stored, prepared and served.*

Criteria

28.5.2.1 Potentially high-risk foods, unprepared food and prepared items are stored separately.

28.5.2.2 Frozen food is defrosted in a refrigerator.

28.5.2.3 Food should reach a temperature of at least 70 degrees Celsius during cooking and reheating.

28.5.2.4 Food waste is placed in covered containers and removed without delay from places where food is prepared.

28.5.2.5 Where the Cook-Chill Process of food preparation is used, reheating of chilled food begins no longer than 30 minutes after the food is removed from the chiller.

28.5.2.6 Where the Cook-Chill Process of food preparation is used, the temperature of the heated food reaches at least 70 degrees Celsius, for not less than two minutes.

28.5.2.7 Food is served within 15 minutes of reheating.

28.5.3 *Food is stored under conditions which ensure security, hygiene and freshness.*

Standard Intent
The food service manager must have a system for ensuring that foods are stored under conditions that ensure security, hygiene and freshness.This requires the documentation of standards and monitoring of the conditions under which foods are stored.

Criteria

28.5.3.1 The manager of the food service ensures that secure storage areas are available to food service personnel.

28.5.3.2 The manager ensures that the foods are checked for quality, quantity and temperature on delivery.

28.5.3.3 The management ensures that the storage of food in dry storage, refrigerators and freezers complies with food hygiene regulations.

28.5.3.4 Foods are stored at acceptable temperatures; thermometers are used, and temperature records are maintained.

28.5.3.5 Appropriate action is taken if the temperatures are persistently outside the recommended range.

28.5.3.6 Foods are stored separately from non-foods.

28.5.3.7 Foods are stored off the ground, on racks or shelving of an impenetrable material.

28.5.3.8 Different types of food are kept separately.

28.5.3.9 Stock is rotated to prevent expiry of perishable items.

28.5.3.10 Pest control measures are implemented.

28.6 Patient care

28.6.1 *The therapeutic nutritional service is managed to ensure the provision of a safe and effective service.*

Standard Intent
Departmental and service managers are primarily responsible for ensuring that the mission of the hospital is met through the provision of management and leadership at departmental level. Good departmental or service performance requires clear leadership from a suitably qualified individual.

The responsibilities of each member of personnel in the department should be documented. Each one should sign their own document to show that they are in agreement with their job description. Documents should be prepared by each department that define its goals and identify both current and planned services. Lines of communication within each department should be documented to ensure clear accountability.

Departmental policies and procedures are essential. They provide personnel with the guidance required to carry out the functions of the department. It is therefore important to have a system in place to ensure that departmental policies and procedures are known, understood and implemented. Policies must be available, indexed, signed, dated and authorised by the hospital leaders. Outdated policies and procedures should be recalled and archived according to hospital policy to prevent the accidental implementation of outdated practices.

Criteria

28.6.1.1 A designated individual is responsible for the therapeutic nutritional service.

28.6.1.2 The therapeutic nutritional service manager ensures that policies and procedures are available to guide personnel and that they are implemented.

28.6.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

28.6.1.4 The responsibilities of the manager are defined in writing.

28.6.2 *All patients treated by dieticians/nutritionists have their healthcare needs identified through an established assessment process.*

Standard Intent

The assessment process needs to be planned and implemented to provide uniform assessments for all patients. Guidelines aid the implementation of uniform assessment processes. These are often available from the professional society. The assessment process should be modified to meet the needs of each patient.

Regular reassessments of patients will ensure that the continuing care plans are suited to the needs of the patients and are essential to justify the treatment plans and ongoing care.

Criteria

28.6.2.1 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

28.6.2.2 The findings of assessments performed outside the hospital are verified on admission.

28.6.2.3 Patients are reassessed at intervals appropriate to their conditions, care plans, individual needs or according to hospital policies and procedures.

28.6.3 *The care provided to each patient is planned and written in the patient's record.*

Standard Intent

Professional personnel have a responsibility to ensure that they are employing up-to-date methods for diagnosis and management, which are broadly consistent with those of other practitioners of the same profession.

Clinical practice guidelines provide a means for improving quality and they assist practitioners and patients in making clinical decisions. Guidelines are found in the literature under many names, including practice parameters, practice guidelines, patient care protocols, standards of practice. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by hospital leaders and practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the catchment population, patient needs and hospital resources. Once implemented, guidelines must be reviewed on a regular basis to ensure their continued relevance.

Adequate medical records are essential for maintaining continuity of care, professional development and medico-legal protection.

Criteria

28.6.3.1 Clinical practice guidelines, relevant to the patients and services of the hospital, are used to guide patient care processes.

28.6.3.2 The implementation of guidelines is monitored as part of a structured clinical audit.

28.6.3.3 Guidelines are reviewed and adapted on a regular basis.

28.7 Patient and family education

28.7.1 *Education supports patient and family participation in care decisions and care processes.*

Standard Intent

The hospital should select appropriate educational methods and people to provide education to patients, their families and caregivers, taking into account factors such as educational literacy, cultural beliefs and personal limitations.

Personnel involved in patient, family and caregiver education should collaborate to ensure that the information patients and families receive is comprehensive, consistent and effective. Education should be focused on the specific knowledge and skills that the patient, family members and caregivers will require to make care decisions, participate in care and continue care at home, e.g.
changing of dressings and administration of medication and/or nutritional supplementation. Education in areas that carry high risk to patients must be provided routinely by the hospital, e.g. instruction in the safe and effective use of medication and medical equipment.

It is important that patients, families and caregivers are made aware of financial implications associated with care choices, such as choosing to remain an inpatient rather than receiving care as an outpatient.

Information relating to the planning and delivery of education should be recorded in a consistent location in the patient record and follow a standardised format.

Community organisations that support health promotion and disease prevention education should be identified and, when possible, ongoing relationships should be established to promote coordinated, holistic patient care.

Criteria

28.7.1.1 Patients and families indicate that they have been informed about participation in the care process.

28.7.1.2 Patients indicate that they have been informed about relevant health risks, e.g. the safe use of medication in relation to medicine/food interactions.

28.7.1.3 Interaction between personnel, the patient and the family is noted in the patient's record.

28.8 Quality improvement

28.8.1 *A formalised proactive quality improvement approach is maintained in the food service.*

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality management structures or systems. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:
- Patient satisfaction
- Complaints about meals
- Stock control
- Monitoring hygiene measures
- Patient assessment
- The success of therapeutic nutritional service procedures carried out
- The availability, contents and use of patient records
- Patient and family expectations and satisfaction

The following will be evaluated:
- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- Identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment does not qualify as a continuous quality improvement process and will be scored NC.

Criteria

28.8.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

28.8.1.2 Indicators of performance are identified to evaluate the quality of the service provided.

28.8.1.3 The quality improvement cycle includes the monitoring and evaluation of the standards set and remedial action implemented.

28.8.1.4 A documentation audit system is in place.

28.9 Patient rights

28.9.1 *The department/service implements processes that support patient and family rights during care.*

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

28.9.1.1 There are processes that support patient and family rights related to food and nutrition.

28.9.1.2 Personnel respect the rights of patients and families and recognise cultural preferences related to meals.

28.9.1.3 Measures are taken to protect the patient's privacy.

28.9.1.4 The personnel respect the rights of patients and families to treatment and to refuse treatment.

28.10 Prevention and control of infection

28.10.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

28.10.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

28.10.1.2 Infection control processes include prevention of the spread of food-related infections.

28.10.1.3 Infection control processes include effective hand washing procedures.

28.11 Risk management

28.11.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

28.11.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

28.11.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of interventions and responses to recorded incidents.

28.11.1.3 Security measures are in place and implemented to ensure personnel safety.

28.11.1.4 Fire safety measures, which include a fire blanket and fire extinguishers, are implemented.

28.11.1.5 The hospital's policy on handling, storing and disposing of waste is implemented.

29 Linen Management

OVERVIEW OF LINEN MANAGEMENT

This Service Element is designed to enable the personnel in the particular service to assess, monitor and improve quality in their own service.

Linen management encompasses all aspects of the provision of clean linen for all patient care services. The linen management service may be provided on site or off site. Whatever system is used, the processes will be assessed in terms of the provision and distribution of linen, stock control, the collection of soiled and infected linen, laundering processes and the re-distribution of linen.

The manager of the service should work with other hospital leaders and managers to improve the quality of care throughout the hospital and to ensure that the linen management service complies with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement. This Service Element therefore strengthens the standards in previous Service Elements but cannot be used in isolation.

Standards

29.1 Management

29.1.1 *The linen management service is managed to ensure the provision of a safe and effective service.*

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the hospital is met through the provision of management and leadership at departmental level. Good departmental or service performance requires clear leadership from a suitably qualified individual. The responsibilities of each member of personnel in the department should be documented. For employees of the hospital, the availability of job descriptions will be assessed with the Human Resource Management Service Element. However, for contracted staff, the manager of the service should have a job description available which will provide the tool for contract monitoring. Each one should sign their own document to show that they are in agreement with their job description.

Documents should be prepared by each department which define its goals and identify both current and planned services. Lines of communication within the department should be documented to ensure clear accountability.

Departmental policies and procedures are essential. They provide personnel with the guidance required to carry out the functions of the department. It is therefore important to have a system in place to ensure that departmental policies and procedures are known, understood and implemented. They should be available, indexed, signed, dated and authorised by the hospital leaders

Criteria

29.1.1.1 A designated individual is responsible for the linen management service.

29.1.1.2 The linen management service manager ensures that policies and procedures are available to guide personnel and that they are implemented.

29.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

29.1.1.4 The responsibilities of the service manager are documented.

29.2 Facilities and equipment

29.2.1 *Where there is a laundry on site, the department is designed to allow for safe and effective processing of linen.*

Standard Intent
Departmental managers need to work closely with hospital managers to ensure that facilities and equipment are adequate. The departmental manager should keep hospital managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

The laundry must comply with all Namibian legislation and regulations relevant to the service, e.g. building regulations and occupational health and safety legislation.
In addition to legislative requirements, the laundry must comply with the following as a minimum:

a) The roof and ceiling should be designed to minimise dust-collecting surfaces
b) The floor should be well graded (sloped) to allow for surface drainage in the washing area
c) Outlets to drains must be clean and covered
d) There should be access to conveniently sited ablution facilities, which may be shared with personnel from other departments
e) Personnel should have access to a tearoom and locker facilities
f) There should be a separate, strategically placed supervisory office, a washing materials store which is dry, a cleaner's area or room and a clean linen store or area

Criteria

29.2.1.1 The space in the laundry is adequate to deal with the calculated or estimated dry weight of articles to be processed and the type of washing equipment.

29.2.1.2 The laundry facilities comply with the requirements listed in (a) – (f) in the intent statement.

29.2.1.3 The laundry provides a clear flow of laundry from the soiled to the clean side with no crossover of these lines.

29.2.1.4 Trolleys, bins, vehicles or other equipment used for the transport of linen bags are designed to avoid damage to linen and to be cleaned easily.

29.2.1.5 Clean overalls, aprons, gloves and footwear for on-site sorting of used linen are provided and correctly used.

29.2.1.6 Adequate hand washing facilities are provided.

29.2.1.7 Washing machines are fitted with water level gauges or dip gauges and the quantity of water is regularly checked.

29.2.1.8 The size and number of washing machines are adequate to meet the number of loads per hour, including peak loads.

29.2.1.9 Ironers/laundry presses are adequate to ensure the processing of laundry items without undue delays.

29.2.1.10 The machine cage volume is specified by the manufacturer.

29.2.1.11 Loads are regularly weighed.

29.2.1.12 Washing machines are fitted with thermometers, which are tested every 6 weeks and calibrated every year.

29.2.2 *Where there is no on-site laundry, the linen-bank facilities allow for efficient handling of linen.*

Criteria

29.2.2.1 The arrangement between the hospital and the off-site laundry clearly states the responsibility for sorting, counting, collection and delivery of linen.

29.2.2.2 Where sorting takes place on site, there is a clear flow of linen from the soiled to the clean side with no crossover of these lines.

29.2.2.3 Trolleys, bins, vehicles or other equipment used for the transport of linen bags are designed to avoid damage to linen and to be cleaned easily.

29.2.2.4 Clean overalls, aprons, gloves and footwear for on-site sorting of used linen are provided and correctly used.

29.2.2.5 Soiled linen sent to the off-site laundry is sorted into bags (or other acceptable containers) which clearly indicate the contents.

29.2.3 *Linen stock control mechanisms are implemented.*

Criteria

29.2.3.1 Access to the laundry/linen-bank is controlled.

29.2.3.2 There is a method of accounting for the numbers of different linen items sent for laundering.

29.2.3.3 There is a process to verify the numbers and physical condition of linen items sent and received.

29.2.3.4 A record is kept of linen issued.

29.2.3.5 Secure storage facilities are available.

29.2.3.6 There is an inventory of all linen stored.

29.2.3.7 Records are audited.

29.2.3.8 All losses are investigated, reported and recorded.

29.3 Policies and procedures

29.3.1 *Policies and procedures guide the management of the service.*

Standard Intent

Departmental policies and procedures give personnel the guidance they require to carry out the functions of the department. It is therefore important to have a system in place to ensure that departmental policies and procedures are known, understood and implemented. They need to be available, indexed, signed, dated and authorised by the hospital leaders. Outdated policies and procedures should be recalled and archived according to hospital policy to prevent the accidental implementation of outdated practices.

It is particularly important that the policies or procedures indicate:

- How planning will occur
- The documentation required
- Special considerations
- Monitoring requirements
- Special qualifications or personnel skills

Policies and procedures should address the following as a minimum:

a) Separation of personnel working in clean and soiled areas
b) Marking of linen to identify ownership
c) Handling of damaged and/or stained linen
d) Washing of patients' private clothing
e) Delivery of clean linen
f) How to obtain clean linen in an emergency
g) Handling of infected linen including high risk infections such as viral haemorrhagic fevers
h) Handling of linen infested with parasites
i) Wearing of protective clothing
j) Searching of used linen for sharps
k) Sorting of linen
l) Labelling of high risk linen within the hospital (e.g. biohazard, radio isotopes, chemotherapy, etc.)
m) Time/temperature combinations of different types of soiled and infected linen
n) Classification of work for processing e.g. colours, fabrics, degree of soiling
o) Maximum capacity loading of machines (weight of dry fabric to cubic capacity of the machine)
p) Maximum capacity loading of dryers (weight of wet fabric to cubic capacity of the machine)
q) Use of chemicals, soaps, sodium chloride solutions and softeners
r) Finishing processes and folding of clean linen

Criteria

29.3.1.1 Policies and procedures, which include items (a)-(r) in the standard intent above as a minimum, are available to guide personnel and are implemented.

29.3.1.2 Policies and procedures are signed by persons authorised to do so.

29.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel.

29.3.1.4 Each policy and procedure is reviewed regularly according to hospital policy.

29.3.1.5 Outdated policies and procedures are recalled and archived according to hospital policy.

29.4 Quality improvement

29.4.1 *A formalised proactive quality improvement approach is maintained in the linen management service.*

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 8). It is the responsibility of the management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of the managers to ensure that standards are set for that particular department. This requires coordination with the hospital's central coordinating quality management structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:
- The availability of clean linen when it is needed
- The amount of stained linen
- The number of items that need to be repaired
- Complaints about linen
- The number of instruments found in operating theatre linen

The following will be evaluated:
- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- Identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as the acquisition of new linen does not qualify as a continuous quality improvement process and will be scored NC.

Criteria

29.4.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

29.4.1.2 Indicators of performance are identified to evaluate the quality of the service.

29.4.1.3 The quality improvement cycle includes the monitoring and evaluation of the standards set and the remedial action implemented.

29.4.1.4 Incidents relating to complaints about the linen management are recorded and acted upon using quality improvement methodology.

29.5 Patient rights

29.5.1 *The department/service implements processes that support patient and family rights during care.*

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4). Compliance will be verified during the observation of patient care processes and patient interviews.

Criteria

29.5.1.1 There are processes that support patient and family rights related to the provision of bed linen to promote patient comfort.

29.5.1.2 Appropriate hospital attire is provided to patients to ensure that their right to dignity is preserved.

29.6 Prevention and control of infection

29.6.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

29.6.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

29.6.1.2 Infection control processes include prevention of the spread of infection related to infected linen.

29.6.1.3 Infection control processes include prevention of the spread of infection related to the separation of soiled and clean linen.

29.6.1.4 The sluicing process has been approved by a hospital's infection control coordinator.

29.6.1.5 Personnel responsible for sluicing are appropriately trained and made aware of the potential hazards associated with sluicing.

29.6.1.6 Infection control processes include effective hand washing procedures.

29.6.1.7 No eating, drinking or smoking is permitted in the laundry areas.

29.7 Risk management

29.7.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

29.7.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of the hospital risk management programme.

29.7.1.2 Material Safety Data Sheet (MSDS) leaflets for chemicals used in the linen service are available in an easily accessible location.

29.7.1.3 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of interventions and responses to recorded incidents.

29.7.1.4 Security measures are in place and implemented to ensure the safety of personnel.

29.7.1.5 Fire safety measures are implemented, which include the provision of fire extinguishers.

29.7.1.6 The hospital's policy on handling, storage and disposal of healthcare waste is implemented.

30 Housekeeping Service

OVERVIEW OF HOUSEKEEPING SERVICE
This Service Element is designed to enable housekeeping personnel to assess, monitor and improve quality in their own service.

The manager of the housekeeping service must work with other hospital leaders and managers to improve the quality of care throughout the hospital and ensure that the service complies with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement. This Service Element, therefore, strengthens the standards in previous Service Elements, but cannot be used in isolation.

30.1 Management of the service

30.1.1 *The housekeeping service is managed to ensure the provision of a safe and effective service.*

Standard Intent
Departmental and service managers are primarily responsible for ensuring that the mission of the hospital is met through the provision of management and leadership at departmental level. Good departmental or service performance requires clear leadership from a suitably qualified individual.

The responsibilities of each member of personnel in the department should be defined in writing. Each one should sign their own document to show that they agree with their job description.

Documents should be prepared by each department which define its goals and identify both current and planned services. Lines of communication within each department should be documented to ensure clear accountability.

Departmental policies and procedures are essential. They provide personnel the guidance required to carry out the functions of the department. It is therefore important to have a system in place to ensure that departmental policies and procedures are known, understood and implemented by all personnel. They should be available, indexed, signed, dated and authorised by the hospital leaders. The departmental manager should prepare cleaning schedules for each hospital area to ensure the hygiene requirements of the hospital are met.

Criteria

30.1.1.1 A designated individual is responsible for the housekeeping service.

30.1.1.2 The housekeeping service manager ensures that policies and procedures are available to guide personnel and that they are implemented.

30.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

30.1.1.4 The responsibilities of the service manager are defined in writing.

30.1.1.5 Pest control measures are implemented.

30.2 Facilities and equipment

30.2.1 *Facilities and equipment are adequate to provide a safe and effective cleaning service.*

Standard Intent
Departmental managers should work closely with hospital managers to ensure that facilities and equipment are adequate. Departmental managers should keep hospital managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

Criteria

30.2.1.1 Secure storage areas and well-maintained equipment are available to housekeeping personnel.

30.2.1.2 Chemicals for cleaning are safely stored out of the reach of patients, children and visitors.

30.2.1.3 Chemicals for cleaning are securely and accurately labelled.

30.2.1.4 There is adequate storage place for brooms and mops.

30.2.1.5 Mops and brooms are cleaned and dried before being stored.

30.2.1.6 Cleaning cupboards are adequately ventilated.

30.2.1.7 Soiled linen is placed in bags designated for that purpose.

30.2.1.8 Soiled linen is stored in a secure facility.

30.2.1.9 There is a mechanism whereby the manager of the housekeeping service can communicate the current state of housekeeping-related facilities and equipment to central facility management.

30.2.1.10 Personal protective equipment (PPE) is available to housekeeping personnel to protect them from infection and the potentially harmful effects of chemicals used during their duties.

30.3 Policies and procedures

30.3.1 *Policies and procedures guide the management of the department.*

Standard Intent
As indicated in 30.1.1, departmental policies and procedures are essential. They provide the guidance personnel require to carry out the functions of the department correctly and consistently. It is therefore important that a system is in place to ensure that departmental policies and procedures are known, understood and implemented.

Policies need to be available, indexed, signed, dated and authorised by the hospital leaders. Outdated policies and procedures should be recalled and archived according to hospital policy to prevent the accidental implementation of outdated practices.
It is particularly important that the policies or procedures indicate:

- How planning will occur
- The documentation required
- Special considerations

- Monitoring requirements
- Special qualifications or personnel skills

Departmental policies and procedures should address as a minimum:

a) The supervision of cleaning personnel
b) Correct and secure labelling of cleaning chemicals
c) The mixing/dilution and use of chemicals for cleaning
d) The safe storage of cleaning materials
e) Hygienic storage of mops and brooms
f) Appropriate cleaning methods and materials for various surfaces
g) Handling of used and infective linen
h) Cleaning at times that are least disturbing to the patient care services
i) Method for cleaning spills of hazardous waste, e.g. bodily fluids and chemicals
j) Preparation, monitoring and review of cleaning schedules

Criteria

30.3.1.1 The departmental manager ensures that policies and procedures, which include items (a)-(j) in the standard intent above as a minimum, are implemented in the department.

30.3.1.2 Policies and procedures are signed by persons authorised to do so.

30.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel.

30.3.1.4 Each policy and procedure is reviewed regularly according to hospital policy.

30.3.1.5 Outdated policies and procedures are recalled and archived according to hospital policy.

30.4 Waste disposal

30.4.1 *The housekeeping personnel work with the infection control committee to ensure safe waste disposal.*

Standard Intent

Housekeeping personnel play an important role in the removal of healthcare waste from departments. Protocols need to be developed to guide housekeepers in ensuring their own safety, the safety of others and the safety of the environment when implementing the waste removal systems.

Criteria

30.4.1.1 Waste is segregated in accordance with documented controls.

30.4.1.2 Housekeeping personnel use colour-coded charts (or other suitable coding) to identify the colour of bag and type of container appropriate to the type of waste generated.

30.4.1.3 Waste is protected from theft, vandalism or scavenging by animals.

30.4.1.4 Waste is collected at appropriate times so that hazards are not caused.

30.5 Quality improvement

30.5.1 *A formalised proactive quality improvement approach is maintained in the housekeeping service.*

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of departmental managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality management structures or systems. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.
Quality monitoring could include:

- The use of cleaning chemicals
- The cleanliness of cleaning equipment
- Infection control measures
- Waste management
- The cleanliness of ablution facilities
- Complaints about cleanliness

The following will be evaluated:

- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC.

Criteria

30.5.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

30.5.1.2 Indicators of performance are identified to evaluate the quality of the service.

30.5.1.3 The quality improvement cycle includes the monitoring and evaluation of the standards set and the remedial action implemented.

30.6 Patient rights

30.6.1 *The department/service implements processes that support patient and family rights during care.*

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4).

Compliance will be verified during the observation of patient care processes and patient interviews.

Criteria

30.6.1.1 There are processes that support patient and family rights related to a clean environment.

30.6.1.2 Personnel respect the rights of patients and families related to protection from healthcare-associated infections by means of appropriate waste management.

30.7 Prevention and control of infection

30.7.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

30.7.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

30.7.1.2 Infection control processes include prevention of the spread of infection related to the cleaning and storage of cleaning equipment.

30.7.1.3 Infection control processes include prevention of the spread of infection related to the correct dilution of cleaning chemicals.

30.7.1.4 Infection control processes include prevention of the spread of infection related to implementing the colour-coded identification of mops for different areas.

30.7.1.5 Infection control processes include effective hand washing procedures.

30.8 Risk management

30.8.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5). Of particular importance in the housekeeping service is the management of cleaning chemicals. These chemicals can cause severe harm in the event of a splash injury or ingestion. Material Safety Data Sheets (MSDS) leaflets should be available in an easily accessible area to guide actions following such an adverse event. These leaflets should be available in the housekeeping service, but it may be useful to have duplicates available with the occupational health service in a larger hospital or the central management offices in a smaller hospital to facilitate a rapid and beneficial response to such incidents.

Criteria

30.8.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

30.8.1.2 MSDS leaflets for chemicals used in the housekeeping service are available in an easily accessible location.

30.8.1.3 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of interventions and responses to recorded incidents.

30.8.1.4 Security measures are in place and implemented to ensure safety of personnel.

30.8.1.5 Fire safety measures are implemented.

30.8.1.6 The hospital's policy on handling, storing and disposing of waste is implemented.

31 Maintenance Service

OVERVIEW OF MAINTENANCE SERVICE
The Maintenance Service is responsible for the management and maintenance of the hospital's plant, machinery, buildings and non-medical equipment.

Ensuring that buildings, grounds, plant and machinery are provided and maintained and do not pose hazards to occupants requires that personnel responsible for these services are knowledgeable and competent.

Utility systems (electrical, water, oxygen, ventilation, vacuum and others) must be maintained to minimise the risk of operating failures.

Namibian Laws, regulations and inspections by national governmental and local authorities determine in large part how the hospital building is designed, used and maintained. All hospitals, regardless of their size and resources, must comply with these requirements as part of their responsibility to patients and their families, personnel and visitors. Hospitals begin by complying with laws and regulations. Over time they should become more knowledgeable about the details of the physical facility they occupy. They should begin to gather data proactively and implement strategies to reduce risks and enhance the patient care environment.

31.1 Management of the service

31.1.1 *The Facility Maintenance Service is managed to ensure the provision of a safe and effective service.*

Standard Intent
A suitably qualified individual with proven competence is appointed to manage the service. The accountabilities and responsibilities of this individual should be clearly defined.

The manager should have access to relevant Namibian laws, regulations and other requirements, e.g., bylaws applicable to the hospital's facilities. The Namibian legislation referred to in criterion 31.1.1.4 is that which relates to the safety of buildings, plant, machinery, electrical installations, water supplies and any other components of the physical facilities of the hospital that require specific, legally mandated attention, such as mandatory safety inspections, etc.

Management is responsible for planning and budgeting for the necessary upgrading or replacement and for showing progress made in meeting those plans. It should be evident that available resources are optimally utilised in providing a safe, effective and efficient hospital.

Criteria

31.1.1.1 A designated individual is responsible for supervising the maintenance of buildings, plant and installations.

31.1.1.2 The responsibilities of the manager are documented.

31.1.1.3 The maintenance manager identifies the requirements of the hospital's maintenance programme, which informs the budgeting process.

31.1.1.4 Laws, regulations and other requirements applicable to the hospital's facilities are available to personnel.

31.1.1.5 Policies and procedures guide personnel in the implementation of Namibian legislation.

31.1.1.6 The manager works with the multidisciplinary team to develop and implement risk management systems according to hospital policy.

31.1.2 *Service facilities and equipment.*

Criteria

31.1.2.1 There is a dedicated work area for maintenance activities.

31.1.2.2 Basic maintenance equipment, tools and spare parts are available.

31.1.2.3 There is a separate area for personnel with adequate, secure storage facilities for outdoor clothing and personal possessions.

31.1.2.4 There are adequate, suitable and conveniently placed change rooms, toilets and ablution facilities for personnel.

31.1.3 *There is an adequate number of suitably qualified and/or experienced personnel to provide a safe and effective service.*

Standard Intent

Management should ensure that an adequate number of competent personnel are available to manage routine and emergency functions to meet the needs of a safe and effective health service. Personnel may be employed directly by the hospital or via contracting arrangements. Where contracted personnel are utilised, their responsibilities should be documented in contracts, service level agreements or equivalent. Personnel should have their roles clearly defined and management should ensure that they maintain competence.

Criteria

31.1.3.1 There are sufficient suitably trained and/or experienced personnel to manage the hospital's buildings, plant and machinery.

31.1.3.2 Where there are no in-house personnel to perform these functions, the services of consultants/service providers are utilised.

31.1.3.3 Contact details for specialist service contractors for buildings, plant and machinery are available, which include the name of the organisation, their location, telephone numbers, responsible persons and specified nominated contact person(s).

31.1.3.4 There is a system for the provision of emergency technical backup.

31.2 Hospital facilities and equipment

31.2.1 *The hospital implements a documented planned preventative maintenance (PPM) programme for buildings, plant, installations and machinery.*

Standard Intent

Planned preventive maintenance (PPM) or more usually just simple planned maintenance (PM) or scheduled maintenance is any variety of scheduled maintenance to an object or item of equipment. Specifically, planned maintenance is a scheduled service visit carried out by a competent and suitable

agent to ensure that an item of equipment is operating correctly and therefore avoid any unscheduled breakdown and downtime.

The first consideration for any physical facility are Namibian the laws, regulations and other requirements applicable to that hospital. Such requirements may differ depending on the age and location of the hospital, or other factors.

The hospital should plan and schedule regular in-house inspections of facilities and testing of plant and machinery to avoid hazards. The hospital's personnel may carry out the testing, or the manufacturer's technicians may carry out these tasks. Whatever the system in use, the hospital should have a documented schedule for testing plant and machinery.

Water quality can change suddenly due to many causes, some of which can be outside the control of the hospital, such as a break in the supply line to the hospital, or contamination of the town or city's water source. An uninterrupted source of clean water is essential to meet routine and urgent patient care needs. Regular and alternative sources such as boreholes can be used. In the event of the overhead reservoir tank being the only alternative source, note that contamination of the town or city's supply is likely to affect the contents of the tank also. It is therefore necessary to have contingency plans in place for the provision of drinkable water from another source.

Water quality is a critical factor in clinical care processes, e.g. renal dialysis. Thus, the hospital should establish a process to monitor water quality regularly, including the regular biological testing of water used in renal dialysis. The frequency of monitoring should be based in part on previous experience with water quality problems. The monitoring can be carried out by individuals designated by the hospital, such as personnel from the clinical laboratory, or by public health or water control authorities outside the hospital. Records of all checks should be available.

Monitoring essential systems will help the hospital to prevent problems and provide the information necessary to make decisions on system improvements and plan for the upgrading or replacement of utility systems.

Criteria

31.2.1.1 Policies and procedures relating to the maintenance of plant, equipment and installations are implemented.

31.2.1.2 The service implements planned preventative maintenance according to a schedule.

31.2.1.3 The department holds regular, documented, current and accurate inspections of the hospital's physical facility, plant and machinery.

31.2.1.4 Records/log books indicate that emergency generators are regularly tested on full load according to manufacturer's specifications.

31.2.1.5 Servicing and testing of the uninterruptible power supplies (UPS) and/or battery backup systems is documented.

31.2.1.6 There is documented evidence that the recommendations of the inspections have been addressed.

31.2.1.7 A documented procedure for reporting defects in maintenance installations during and after normal working hours is known to departmental and hospital personnel.

31.2.1.8 Records indicate that upgrading, replacement, de-commissioning and/or disposal of operational plant are undertaken according to hospital policy.

31.2.1.9 There are site and floor plans that depict the locations and layout of the main services (i.e. water, sanitation, electricity supply).

31.2.1.10 Records indicate that the sewerage management system is maintained according to hospital policy.

31.2.2 *Medical gas systems are regularly inspected, maintained and when necessary improved.*

Standard Intent
The hospital should plan its needs for oxygen supplies according to the needs of the patients served.

Policies and procedures should be available and followed relating to the storage, testing and safety of gas supplies. Gas cylinders must be stored chained in the upright position in outside storage areas that have appropriate safety warning signs in the form of "no entry", "no naked flames", "no smoking" and, in the case of oxygen, "no oil".

Where there is no piped oxygen there must be at least one mobile oxygen cylinder per ward or more, depending on the number of beds/cots in the ward. All necessary fittings for oxygen must be suitable for all patients, including children, and must be working satisfactorily. Emergency oxygen supplies must ensure that the number of available outlet points meet patient needs.

Criteria

31.2.2.1 Medical gas (oxygen, nitrous oxide and medical air) supplies are available according to the operational requirements of the hospital.

31.2.2.2 Medical gas supply systems comply with safety standards.

31.2.2.3 Where there is piped gas, the enclosure, gas bank, pressure regulators, related control/alarm systems and all outlet points are clean and in good operating condition.

31.2.2.4 Where there is piped gas, the main oxygen supply system is fitted with an alarm, which operates automatically in the event of low pressure in the gas supply system and is regularly tested and documented.

31.2.2.5 Documented testing of medical gas alarm systems is undertaken regularly according to hospital policy.

31.2.2.6 Backup supplies of medical gases are available and strategically positioned to ensure timely deployment in emergencies.

31.2.3 *Medical vacuum systems are regularly inspected and maintained.*

Standard Intent
The hospital should plan its needs for vacuum supplies according to the needs of the patients served. Policies and procedures relating to the testing and safety of piped vacuum systems and mobile/portable electric or manual suction units must be available and implemented.

Vacuum systems must be tested regularly in accordance with Namibian arrangements or manufacturer's instructions.

Criteria

31.2.3.1 Where there is a piped vacuum system, it is externally ventilated and able to provide sufficient suction to all piped vacuum points in the hospital.

31.2.3.2 In the event of failure of the piped vacuum/suction facilities, backup facilities are provided in relevant services.

31.2.3.3 Where there are no piped vacuum facilities installed, portable/mobile vacuum/suction units are available and strategically positioned to ensure timely deployment in emergencies.

31.2.4 *Functional facilities are available to provide safety and comfort for patients and personnel.*

Standard Intent

Namibian laws, regulations and inspections by national government and local authorities determine in large part how a hospital is designed, used and maintained. All hospitals, regardless of size and resources, must comply with these requirements as part of their responsibilities to their patients, families, personnel and visitors.

The construction of the building in terms of walls, ceilings, floors, doors and windows must be sound and the appearance should be neat and in good condition, e.g. no peeling paint, signs of leakage, visible mould spots, exposed electrical wiring, switches and electrical sockets, the grounds litter free with neat gardens and short grass.

Criteria

31.2.4.1 Sufficient office/administrative space is available for personnel.

31.2.4.2 Where required, air-conditioning is installed in laboratories, pharmacies, operating theatres and sterilising departments and is tested and maintained according to hospital policy or manufacturer's guidelines.

31.2.4.3 Temperature and ventilation control mechanisms are installed in the kitchen, laundries and other relevant areas and tested and maintained according to hospital policy or manufacturer's guidelines.

31.3 Emergency preparedness

31.3.1 *The hospital has a process to protect hospital occupants in the event of electrical system disruption or failure, which is tested on a regular basis.*

Standard Intent

The hospital should protect patients and personnel in emergencies, such as system failure, interruption or contamination. To prepare for such emergencies, the hospital must identify the equipment, systems and locations that pose the highest risk to patients and personnel.

For example, the hospital should:

- Identify where there is a need for illumination, refrigeration and life support

- Assess and minimise the risk of total utility system failures in these areas
- Test the availability and reliability of emergency sources of power
- Document the results of tests

An uninterrupted source of electricity is essential to meet routine and urgent patient care needs. Regular and alternate sources can be used. Critical locations which will require emergency power include:

- Operating theatres and recovery rooms
- Delivery rooms' lights and sockets
- Strategic lights and sockets in ward corridors
- Critical care wards
- The neonatal nursery
- Casualty and trauma areas

Emergency electricity supply must be tested regularly according to hospital policy and records of all checks must be available. Monitoring data for the medical utility management programme should be collected and documented and used for the purposes of planning and improvement.

Criteria

31.3.1.1 Electrical power is available continuously from regular and emergency sources.

31.3.1.2 Emergency electricity supply is available in the areas and services that present the greatest patient safety risk during a power failure.

31.3.1.3 Sufficient fuel, e.g. diesel, is available to provide power for 24 hours.

31.3.1.4 The hospital ensures that relevant personnel are trained to use/operate emergency electrical supply systems.

31.3.2 *Water supplies are regularly inspected, tested, maintained and, when appropriate, improved.*

Standard Intent

An uninterrupted source of clean water is essential to meet routine and urgent patient care needs.
Drinkable water must be available in all essential areas e.g. wards, OPD and ablution facilities.
Regular and alternative sources can be used.
Storage areas such as a well, storage tanks or other backup systems must be safe from contamination.
In addition, the hospital should identify the areas requiring clean water for cleaning and sterilisation purposes. These areas must always have access to clean water.

Criteria

31.3.2.1 Regular and emergency water supplies, including drinkable water, are available continually.

31.3.2.2 All water supplies are tested, and the results are documented on a regular basis.

31.3.2.3 Should the water supply be contaminated or interrupted, the areas and services at risk have been identified and provision has been made for an alternative water supply.

31.3.2.4 There is documented evidence that relevant personnel are regularly trained to ensure that all operations to secure safe water are properly performed.

31.4 Quality improvement

31.4.1 *A formalised proactive quality improvement approach is maintained in the service.*

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7).

It is the responsibility of the central management team of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of service managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality improvement structures or systems. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement
Quality monitoring could include:

- Percentage of backlog in repairs
- Number of call-backs (repeat repairs)
- Number of preventative maintenance inspections done
- Number of call-outs
- Downtime on equipment/plant/machinery
- Personnel productivity indexes
- Number of negative incidents

The following will be evaluated:

- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC.

Criteria

31.4.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

31.4.1.2 Indicators of performance are identified, to evaluate the quality of the service.

31.4.1.3 The quality improvement cycle includes the monitoring and evaluation of the standards set, and remedial action implemented.

31.5 Prevention and control of infection

31.5.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

31.5.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

31.5.1.2 Infection control processes include prevention of infection by using appropriate protective clothing in high risk clinical areas.

31.5.1.3 Infection control processes include effective hand washing procedures.

31.6 Risk management

31.6.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).

Criteria

31.6.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

31.6.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of interventions and responses to recorded incidents.

31.6.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

31.6.1.4 Fire safety measures are implemented.

31.6.1.5 Hospital policy on handling, storing and disposing of healthcare waste is implemented.

32 Medical Equipment Management Service

OVERVIEW OF MEDICAL EQUIPMENT MANAGEMENT SERVICE

Medical equipment management is defined as "An accountable, systematic approach to ensuring that cost-effective, safe, efficacious and appropriate equipment is available to meet the demands of quality patient care" (ECRI, 1989).

In this manual, medical equipment management relates to all aspects of medical equipment support, whereas the general maintenance service (Service Element 31) is responsible for all non-medical equipment.

Hospitals must establish appropriate medical equipment management structures and processes to ensure improved healthcare delivery, which includes the provision of safe, affordable, appropriate, effective and sustainable healthcare technology. In hospitals that have an in-house Clinical Engineering Department or medical equipment workshop, suitably qualified and trained personnel should provide the required technical support, according to the services offered by the hospital and the equipment required to offer these services.

Where there is no in-house clinical engineering practitioner, the hospital should have ready access to suitably trained technical support from an external source, e.g. Department of Health/group/company/regional/district

medical equipment workshop, or an appropriately contracted and suitable service provider, in accordance with hospital policy.

The management of medical equipment should be coordinated throughout the hospital. This is best achieved by appointing an advisory committee, coordinated by an appropriately experienced person to plan and oversee this process. Responsibilities of this committee should include:

Acquisition of new technology

When the acquisition of new technology is planned, this committee should advise on the competence of personnel to maintain the new technology and the age, maintenance, integration, interfacing, user training, storage and disposal of the technology.

Coordination with other healthcare services

The advisory committee must communicate with other hospital committees such as theatre users, infection control, resuscitation, health and safety and quality improvement to ensure that medical equipment management services are fully coordinated with other related healthcare services.

Training

Regular training in the safe and correct usage of all medical equipment utilised within the hospital should be made available to all personnel who use the equipment.

Risk and quality management

Risk management and quality assurance and improvement processes should be planned by the committee in coordination with other services. The implementation of these plans should be overseen by the committee, who should also evaluate the effectiveness of these plans and adjust them where necessary in response to these evaluations, as part of the on-going quality monitoring of the service.

Meetings of the advisory committee must be held on a regular basis and accurate minutes kept to record discussions held, decisions taken and track completion of action points.

Medical equipment management includes compiling an inventory, conducting regular inspections, performing tests and conducting preventative maintenance. The effectiveness of medical equipment management is dependent on the knowledge and skills of those professionals qualified to provide the

equipment management service and also of those who use the equipment. The medical equipment maintenance manager is responsible for implementing programmes for training and education.

Managers in each patient care unit must take responsibility for ensuring that medical equipment is available and appropriately maintained in their units. They are also responsible for ensuring that personnel are thoroughly competent in the use of the medical equipment they use in the performance of their duties. This requires collaboration between hospital management, clinical leaders and those responsible for medical equipment management and technical support. Those individuals who finance, order, receive, maintain, repair and use medical equipment should be included in the collaborative process.

32.1 Medical Equipment Support

32.1.1 *Adequate human resources are available for the Medical Equipment Management Service (MEMS) to ensure safety and the correct management, usage and operation of medical equipment.*

Standard Intent
Hospitals have a responsibility to ensure that appropriate medical equipment is available and ready for use at all times. Suitably qualified or trained individuals should take responsibility for ensuring the provision, maintenance, checking and servicing of medical equipment. These responsibilities must be defined in writing.
There should be an accountable, systematic approach to ensuring that cost-effective, safe, efficacious and appropriate medical equipment is available to meet the demands of quality patient care. The mission and objectives of the hospital, level of technology and geographic location determine the scope of medical equipment support, which may include:

- An in-house medical equipment management and maintenance service
- A medical equipment management and maintenance service at a regional or district level
- The use of outside service providers for equipment maintenance and repairs

The management of this service can only take place if there is adequate documentation of protocols to provide support and guidance. Policies and procedures must be developed in line with current legislation and should include the acquisition, allocation and utilisation of equipment and technical support for MEMS. Policies and procedures relating to the acquisition of equipment should include:

a) Technical support requirements and spares
b) Regulatory compliance when applicable to the equipment under consideration, i.e. compliance with International Electrotechnical Commission (IEC) and other international and/or local standards where such standards exist
c) Compatibility with other equipment
d) Suitability for the stated clinical function(s)
e) Life cycle costing/cost of ownership
f) Supplier evaluation
g) Past experience
h) Accessories

Policies and procedures relating to deployment of equipment should include:

a) Availability and preparation of facilities
b) Installation and commissioning
c) Safety checks
d) Final acceptance checks
e) Connectivity
f) Integration

g) Interfacing
h) User training
i) Storage and usage of disposables/consumables with limited shelf life

Where the hospital employs its own clinical engineering personnel (i.e. an in-house clinical engineering department) the medical equipment manager will refer to a clinical engineer, clinical engineering technician, medical equipment technician, or other suitably trained and/or experienced person, as permitted by legislation.

Matters relating to healthcare technology and the management thereof normally fall within the general ambit of Clinical Engineering (CE). In-house CE departments (CEDs) vary in both size and level of capability according to the size and category of the hospital concerned.

For the purposes of this document, the descriptor "Clinical Engineering Department" (or its acronym "CED") shall be taken to mean any formally organised in-house facility or service intended to actively manage, maintain or repair medical and/or surgical equipment, devices and instrumentation – regardless of the hospital's internal descriptor for such a facility or service.

The onus is on the hospital's management to ensure that personnel are suitably qualified and/or competent and that CEDs are appropriately equipped to perform all functions expected of them. This should be according to any requirements laid down by legislation and/or included in guidelines provided by relevant standards, hospitals and/or recognised professional bodies.

Large tertiary level hospitals are likely to have a CED consisting of separate departments or workshops for each of the main equipment categories (e.g. anaesthesia related, life support and resuscitation, respiratory, surgical instrumentation and radiology, etc.). In some cases, this level of CED serves the needs of a number of other hospitals as well as its own.

CEDs at smaller regional and district level hospitals may vary from small, multidisciplinary workshops to a CE presence, the main functions of which would be to provide first-line response to emergencies, implement risk management processes, monitor the activities of outside service providers and participate in user training. This system may also apply in smaller private hospitals.

Whatever the size and complexity of the in-house CED, a suitably qualified and experienced person should be responsible for ensuring the safety, correct management, usage and operation of the medical equipment within the hospital concerned.

Criteria

32.1.1.1 A medical equipment maintenance manager is designated by the hospital.

32.1.1.2 The responsibilities of the medical equipment maintenance manager are defined in writing.

32.1.1.3 Policies and procedures developed in accordance with Namibian legislation guide personnel in the acquisition, allocation and utilisation of equipment and technical support for MEMS.

32.1.1.4 A multidisciplinary advisory committee is appointed to represent managers, clinical and technical personnel involved in the management and use of medical equipment.

32.1.1.5 Members of the committee are appointed in writing, based on their competence in the area of healthcare technology management.

32.1.1.6 The responsibilities of the committee are documented.

32.1.1.7 The committee meets regularly to discuss and advise on issues relating to healthcare technology management and these meetings are minuted.

32.1.1.8 The committee has ready access to a reliable source of expertise relating to healthcare technology.

32.2 Medical Equipment Management

32.2.1 *Medical equipment is managed and maintained throughout the hospital.*

Standard Intent
To ensure that medical equipment is available for use and is functioning properly, the hospital should:

- Perform an audit on available medical equipment
- Take an inventory of medical equipment, which includes description, make, manufacturer, model, serial number, tracing number, date of purchase, purchase price, list of accessories, supplier details and guarantee expiry dates
- Conduct regular inspections of medical equipment
- Test medical equipment, as appropriate to its use and requirements -Provide planned preventative maintenance

Equipment should be inspected and tested when new and then on an ongoing basis according to the manufacturer's instructions, or as appropriate to the age and use of the equipment. Scheduling of medical equipment maintenance should be prioritised to ensure that the equipment most important to service delivery and potentially highest risk to patients is not overlooked due to mismatch between available resources and workload. Prioritisation can be according to the mission of the hospital, risk of lack of maintenance, equipment maintenance requirements or available resources. [Medical Equipment Maintenance Programme Overview, WHO 2011]

Inspections, testing results and maintenance activities are documented. This helps to ensure the continuity of the maintenance process and provides useful information when capital planning for replacements, upgrades and other changes is being undertaken.

Criteria

32.2.1.1 An audit of medical equipment is conducted.

32.2.1.2 There is a comprehensive inventory of all medical equipment.

32.2.1.3 Operator and/or service manuals are available to operators and technicians at all times.

32.2.1.4 Operator and/or service manuals for donated equipment are available in local languages.

32.2.1.5 Initial commissioning records are available for all high risk medical equipment, which include details of tests performed and training given.

32.2.1.6 The hospital develops and implements a planned preventative inspection and maintenance system according to the service requirements specified by the manufacturers.

32.2.1.7 The manager identifies the requirements of the hospital's medical equipment maintenance programme, which informs the budgeting process.

32.2.1.8 There is a service history for each piece of equipment, which includes signed and dated job-cards detailing all time and expenses associated with maintaining the device, e.g. procedures carried out, time taken to complete the procedure, parts fitted, etc.

32.2.1.9 Patient care unit managers have access to information on service and repairs of equipment.

32.2.1.10 A documented system which addresses the provision of basic technical support in first line emergency situations is in place and known to all relevant persons.

32.2.1.11 Advanced technical support is provided in emergency situations.

32.2.1.12 Names of specialist service contractors are available with their locations, telephone numbers and the responsible persons specified.

32.2.1.13 . Where there are in-house clinical engineering personnel the department has access to all specialised test equipment and consumables (as specified by the manufacturer of the medical equipment) for the equipment they are expected to maintain.

32.2.1.14 Where there are in-house clinical engineering personnel, the tools and test equipment required to offer the service are appropriately maintained.

32.2.1.15 Where there are in-house clinical engineering personnel, they are provided with access to appropriate support documentation, such as equipment standards and other regulatory documentation.

32.2.1.16 Checklists are available for the inspection and maintenance of each type of device in use in the hospital.

32.2.1.17 Where there are in-house clinical engineering personnel, the service develops and implements a system to obtain information on medical device hazard alerts or safety bulletins and responds to the information appropriately.

32.3 Personnel Training

32.3.1 *There are systems in place to ensure that all users of medical equipment and devices are competent in the use thereof.*

Standard Intent

The complexity of medical equipment requires that all users and operators receive training and education in its operation. Ancillary personnel who impact on technology utilisation and/or availability, e.g. stores department personnel, should receive appropriate basic training which may include identification of medical equipment, devices, accessories and common spares, etc.

The hospital has a responsibility to facilitate professional development and competence for personnel in matters relating to medical equipment management and personnel have a responsibility to maintain their own competence and current knowledge.

Criteria

32.3.1.1 Training is provided for all users of basic medical equipment, with a record of all such training given and successfully completed.

32.3.1.2 Training is provided for all users of complex and/or critical life-support equipment, with a record of all such training given and successfully completed.

32.3.1.3 Training in basic electrical safety is provided to all personnel involved in the use of electrically operated equipment.

32.3.1.4 Where clinical engineering personnel are employed, they are provided with appropriate training in respect of all medical equipment, devices and instruments, which they are expected to maintain and/or repair.

32.3.1.5 Where clinical engineering personnel are employed, they are encouraged and assisted by management to attend seminars, congresses, conferences and training sessions, to improve their knowledge of and proficiency in medical technology matters.

32.4 Equipment Safety

32.4.1 *Where clinical engineering personnel are employed, systems are in place to ensure safe working conditions and the safety of equipment in clinical engineering workshops.*

Standard Intent

Management should ensure that equipment is tested and maintained in a safe working environment. Risk management processes should include identifying possible hazards to both patients and personnel and formulating and implementing processes or procedures to minimise the risks associated with these hazards. Such hazards can arise from faulty or out-of-calibration equipment or user error, or as a result of unfamiliarity with the operation of a specific device. It is the responsibility of those working with equipment to ensure that both it and the environment are safe.

Regardless of whether there is an in-house clinical engineering department/service or not, the Medical Equipment Management Committee, together with the management of the hospital, is responsible for ensuring that safety standards are maintained. It is of the utmost importance to note that safety and risk management considerations go beyond just the medical devices themselves and include all hazards associated with the usage, maintenance, repair, storage and disposal of such devices/equipment with regard to the patient, user/operator, other personnel and the general public.

Hazards should be identified and documented for each type of device in use at the hospital.
Examples of such hazards would include gases such as ethylene oxide, nitrous oxide, nitric oxide (and its by-product nitrogen dioxide), mercury, mercury vapour and the vapours of volatile anaesthetic agents and cleaning fluids such as benzene, trichloroethylene, thinners, etc.

In order to ensure that personnel are aware of their responsibilities regarding the handling and disposal of hazardous substances, it is necessary that they are familiar with both the possible dangers and the requirements of the relevant Namibian legislation. To this end, personnel must have ready access to

pertinent documentation, such as a toxicology or material safety data sheet (MSDS) for each substance and copies of all relevant acts, regulations and standards.
(MSDS: A fact sheet summarising information about material identification, hazardous ingredients, health, physical and fire hazards, first aid, chemical reactivities and incompatibilities, spill, leak and disposal procedures and protective measures required for safe handling and storage).
Relevant Namibian legislation regarding occupational health and safety, hazardous substances, the environment, etc. must be available in the department and all activities and processes in the department must comply with these legislative requirements.

Criteria

32.4.1.1 Clinical engineering personnel implement risk management processes in accordance with the hospital risk management systems.

32.4.1.2 There is an adequate scavenging system for the removal of nitrous oxide and volatile anaesthetic agents in the medical equipment workshop.

32.4.1.3 Where anaesthetic vaporisers are tested and serviced in the workshop, a suitable fume extraction chamber is provided.

32.4.1.4 Where extensive soldering work is undertaken, soldering stations are provided with a suitable fume extraction system.

32.4.1.5 Where volatile cleaning agents are used, an appropriate fume extraction chamber is provided for the safe dispersal of hazardous vapours, e.g. ether.

32.4.1.6 The medical equipment workshop has adequate 15 amp surge-protected electrical power outlets.

32.4.1.7 The medical equipment workshop is fitted with air-conditioning capable of maintaining a year-round constant temperature of 21 degrees Celsius.

32.5 Quality Improvement

32.5.1 *A formalised proactive quality improvement approach is maintained in the service.*

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7).It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of departmental managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality management structures or systems. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

- Frequency and duration of use of equipment
- User training and training evaluation
- Equipment downtime
- Incidents
- Number or percentage of "call-backs" (repeat repairs)
- Repair turn-around times of in-house and/or external technical support
- Cost analysis of in-house and/or external technical support
- Number or percentage of equipment failures and user errors

The following will be evaluated:

- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators
- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC

Criteria

32.5.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

32.5.1.2 Indicators of performance are identified to evaluate the quality of the service.

32.5.1.3 The quality improvement cycle includes the monitoring and evaluation of the standards set and remedial action implemented.

32.6 Prevention and Control of Infection

32.6.1 *The department/service implements infection prevention and control processes.*

Standard Intent

This refers to the implementation of hospital processes for infection prevention and control (Service Element 8). All personnel must participate in the hospital's in-service training programme for infection control and ensure that supplementary in-service training specific for the Medical Equipment Maintenance Service is provided and attended.

Criteria

32.6.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

32.6.1.2 Infection control processes include prevention of infection by using appropriate protective clothing in high risk clinical areas.

32.6.1.3 Infection control processes include effective hand washing procedures.

32.6.1.4 Infection control processes include in-service training on appropriate disinfection of medical equipment as part of the maintenance process.

32.7 Risk Management

32.7.1 *The department/service implements risk management processes.*

Standard Intent

This refers to the implementation of hospital risk management processes (Service Element 5). All personnel participate in the hospital's in-service training programme for risk management (including resuscitation) and ensure that supplementary in-service training specific for the Medical Equipment Maintenance Service is provided and attended.

Criteria

32.7.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

32.7.1.2 A system for monitoring near misses/adverse events/sentinel events is available and includes the documentation of interventions and responses to recorded incidents.

32.7.1.3 Security measures are in place and are implemented to ensure the safety of personnel.

32.7.1.4 Fire safety measures are implemented.

32.7.1.5 The hospital's policy on handling, storing and disposing of healthcare waste is implemented.

33 Medical Physics Service

OVERVIEW OF MEDICAL PHYSICS SERVICE

The hospital is responsible for ensuring that the medical physics service meets the needs of its catchment population, the clinical services offered and the healthcare providers.

These needs may be met by a service within the hospital or may be outsourced. In either case, the medical physics service must comply with all applicable local and national Namibian standards, laws and regulations.

The hospital leaders must ensure that where a medical physics service is provided by the hospital, there are radiation safety programmes in place and that individuals with adequate training, skills, orientation and experience are available to undertake the procedures and interpret the results.

33.1 Management of the service

33.1.1 *A medical physics service is provided by the hospital, or is readily available through arrangements with outside sources, to meet the needs of its catchment population.*

Standard Intent

The hospital should have a system for providing the medical physics services required by its catchment population, clinical services offered, and healthcare provider needs. These services, including those required for emergencies, may be provided within the hospital, by agreement with another hospital, or both. The medical physics imaging service should be available after normal hours for emergencies.
Outside sources should be convenient for the patient to access and reports must be received in a timely manner to support continuity of care. They should be selected by the hospital on the recommendation of the director or another individual responsible for medical physics services. Outside sources of medical physics must meet applicable Namibian laws and regulations and have an acceptable record of accurate, timely service
Patients should be provided with the complete details of the outside source of medical or radiation physics service.

Criteria

33.1.1.1 Adequate, convenient and regular medical physics services are available to meet needs.

33.1.1.2 An emergency medical physics service is available after normal hours.

33.1.1.3 The selection of an outside source is based on an acceptable record and compliance with laws and regulations.

33.1.1.4 Patients are informed about any relationships between the referring physician and an outside source of medical physics services.

33.1.2 *A qualified individual is responsible for managing the medical physics service.*

Standard Intent

The hospital must have an active radiation safety programme appropriate to the risks and hazards encountered. The programme must address safety practices and prevention measures for medical physics personnel, other associated personnel and patients. The programme must be coordinated with the hospital's safety management programme.
The radiation safety programme should include:

- Documented policies and procedures that support compliance with applicable Namibian standards, laws and regulations
- Documented policies and procedures for the handling and disposal of infectious and hazardous materials
- The availability of safety protective devices appropriate to the practices and hazards encountered
- The orientation of all medical physics and associated personnel to safety procedures and practices
- In-service education for new procedures and newly-acquired or recognised hazardous materials and equipment
-

Criteria

33.1.2.1 A medical physicist, who is qualified by education, training and experience, manages the medical physics service.

33.1.2.2 The responsibilities of this person include developing, implementing and maintaining relevant policies and procedures.

33.1.2.3 The responsibilities of this person include administrative control.

33.1.2.4 The responsibilities of this person include maintaining quality control programmes.

33.1.2.5 The responsibilities of this person include recommending outside sources of medical physics services.

33.1.2.6 The responsibilities of this person include monitoring and reviewing all medical physics services.

33.1.3 *Individuals with adequate training, skills and experience perform medical physics procedures and interpret the results.*

Standard Intent

The hospital should identify those personnel who may perform procedures and those who may interpret and report on the findings. These individuals should have appropriate and adequate training, experience and skills and should be oriented to their work. Medical physicists should be given assignments consistent with their training and experience. There should be sufficient personnel to provide necessary staffing during all hours of operation and for emergencies.

The hospital should be able to identify and contact experts in specialised areas such as radiation physics, radiation oncology or nuclear medicine when the need for such services arises. The hospital should maintain a roster of such experts.

Criteria

33.1.3.1 Those individuals, who may perform medical physics procedures and those who may interpret and report the results are identified.

33.1.3.2 A mechanism exists which ensures that procedures are performed only by qualified medical physicists, or specially trained doctors and other persons authorised to do so by a radiation protection advisor.

33.1.3.3 Medical physics procedures are done only upon a signed request from a qualified medical practitioner.

33.1.3.4 There is an adequate number of qualified medical physicists to provide the services within the scope of their profession.

33.1.3.5 Experts in specialised medical physics areas are contacted when needed.

33.1.3.6 A roster of experts for specialised medical physics areas is maintained.

33.1.4 *Personnel are provided with documented policies and guidelines for all aspects of the provision of medical physics services*

Standard Intent
Documented guidelines and policies and procedures are essential to guide personnel in the medical physics services in their activities. The existence of documented policies does not preclude modification in the best interests of the patient.
Medical physics policies and procedures should be related to the requirements or availability of other services in the hospital environment.

Criteria
33.1.4.1 All radiation workers are oriented to safety procedures and practices.

33.1.4.2 Personnel receive education for new procedures and newly acquired or recognised hazardous materials and apparatus.

33.1.4.3 Policies and procedures relating to limiting the irradiation of patients and personnel to levels consistent with clinical requirements are implemented.

33.1.4.4 Policies and procedures relating to the terms under which pregnant women may be subjected to any radiation exposure are implemented.

33.1.4.5 Policies and procedures relating to avoiding radioactive contamination and controlling spread should it occur are implemented.

33.1.4.6 Policies and procedures relating to procedures to be followed in the event of contamination, radiation emergency and overexposure are implemented.

33.1.4.7 Policies and procedures relating to monitoring the hands, clothing and body of every member of personnel leaving a controlled area are implemented.

33.1.4.8 Policies and procedures relating to all trials, clinical or other, involving ionising radiations are implemented.

33.1.4.9 Policies and procedures addressing the handling and disposal of infectious and hazardous materials are implemented.

33.2 Administration of radiation tests and treatments

33.2.1 *Individuals with adequate training, skills, orientation and experience administer all tests and treatments.*

Standard Intent
The hospital should identify which members of personnel assess patients, which may prescribe and apply treatment, and which are responsible for guaranteeing that the prescribed radiation doses are

correct. Personnel must have appropriate and adequate training, experience and skills and should be oriented to their work. Personnel should be given work assignments consistent with their training and experience. In addition, there should be a sufficient number of personnel to perform procedures promptly and provide necessary staffing during all hours of operation and for emergencies.

Criteria

33.2.1.1 Diagnostic and therapeutic procedures utilising radiation and/or radiation treatments are planned and performed only upon a formal written prescription from a qualified physician.

33.2.1.2 A radiation oncologist or nuclear medicine physician, or a registrar under the supervision of such a physician, prescribes and monitors the treatment of the patient.

33.2.1.3 An effective mechanism exists whereby emergency medical physics services are initiated promptly.

33.2.1.4 Documents are appropriately filed and/or distributed.

33.2.1.5 Mechanisms exist whereby records of procedures can be retrieved when necessary.

33.3 Radiation safety

33.3.1 *A radiation safety programme is in place, is implemented and is documented.*

Standard Intent

The hospital must have an active radiation safety programme appropriate to the risks and hazards encountered. The programme must address safety practices and prevention measures for medical physics personnel, other associated personnel and patients. The programme must be coordinated with the hospital's safety management programme. The radiation safety programme should include:

- Documented policies and procedures that support compliance with applicable Namibian standards, laws and regulations
- Documented policies and procedures for the handling and disposal of infectious and hazardous materials
- The availability of safety protective devices appropriate to the practices and hazards encountered
- The orientation of all medical physics and associated personnel to safety procedures and practices
- In-service education for new procedures and newly acquired or recognised hazardous materials and equipment

Criteria

33.3.1.1 A qualified medical radiation physicist is available to fulfil the legal requirements of the regulations for the safe use of ionising radiation.

33.3.1.2 A copy of the local rules relating to current ionising radiation regulations is available.

33.3.1.3 A radiation safety programme is in place and is appropriate to the risks and possible hazards encountered.

33.3.1.4 The programme is coordinated with the hospitals risk management programme.

33.3.1.5 Personal dosimeters worn by personnel comply with the ionising radiation regulations.

33.3.1.6 Appropriate radiation safety devices are available.

33.3.1.7 Written records of radioactive stocks, calculation and preparation, administration and disposal details are kept.

33.3.1.8 A register of sealed sources is kept.

33.3.1.9 Facilities are available for testing the integrity of all sealed sources.

33.3.1.10 Contamination monitors and safety mechanisms are available.

33.3.1.11 Area monitors are available where necessary.

33.3.2 *All medical physics related equipment is regularly inspected and maintained and appropriate records are kept of these activities.*

Standard Intent

Medical physics personnel should work with the medical equipment management service to ensure that all equipment and facilities function at acceptable levels and in a manner that is safe to the operator(s). A medical physics equipment management programme should provide for:

- Selecting and acquiring equipment
- Identifying and taking inventory of equipment
- Assessing equipment use through inspection, testing and maintenance
- Monitoring and acting on equipment hazard notices, recalls, reportable incidents, problems and failures
- Documentation of the management programme
- Testing and maintenance are related to the use of the equipment and its documented history of service.

Criteria

33.3.2.1 The medical physicist is a member of the hospitals Healthcare Technology Advisory Committee.

33.3.2.2 Policies and procedures relating to medical physics equipment safety and management complying with current applicable legislation and standards are implemented.

33.3.2.3 There is a medical physics equipment management programme.

33.3.2.4 The programme includes selecting and maintaining the equipment.

33.3.2.5 The programme includes taking an inventory of equipment.

33.3.2.6 The programme includes the inspecting, testing, quality control and continuous monitoring of equipment.

33.3.2.7 The programme ensures that all equipment used complies with the requirements of the regulations of the Radiation Authorities including regular and recorded calibration of all radiation monitoring equipment.

33.3.3 *Facilities ensure the safe, efficient and effective functioning of the medical physics service.*

Standard Intent
Medical physics personnel should work with management to ensure that facilities provide for safety and comply with current radiation (ionising and other hazardous radiations) laws and regulations.

Criteria

33.3.3.1 Facilities ensure that radiation to all personnel is kept as low as possible.

33.3.3.2 Signs warning of the dangers of radiation are prominently displayed.

33.3.3.3 Requirements laid down by the Department of Health or other authority regarding controlled and supervised areas are implemented.

33.3.3.4 A copy of the most recent radiation safety inspection report(s) is available.

33.3.3.5 There is a shower available in the event of contamination.

33.3.3.6 Separate toilets for personnel and patients are available.

33.3.4 *Radioactive materials (open and sealed sources) intended for administration to, or implantation into, patients are prepared in a manner which satisfies both radiation safety and pharmaceutical quality requirements.*

Standard Intent
Sound quality control systems are essential to providing excellent medical physics services.
Quality control procedures should include:

- Validation of the procedures used
- Regular and frequent surveillance of results by a medical physicist
- Rapid corrective action when a deficiency is identified
- Documentation of results and corrective actions

Criteria

33.3.4.1 Appropriate aseptic precautions are taken for each application.

33.3.4.2 The radio-pharmacy is designed to ensure the history of each radio-pharmaceutical dose can be traced.

33.3.4.3 Radio-pharmaceuticals and radioactive implants are only dispensed or prepared on the written request of a qualified medical practitioner.

33.3.4.4 Each preparation of sealed sources is recorded with the dose plan, calculations and all relevant details.

33.3.4.5 All containers with radioactivity are labelled according to specifications, stating that the contents are radioactive and indicating the radio-nuclide, the activity and the date.

33.3.5 *The management and treatment of organ disease using radio-nuclides is practised considering the safety and well-being of patients and personnel as a consequence of the high radiation levels.*

Standard Intent
Where open radio-nuclides are used, all personnel and patients in the hospital must be protected from exposure to radiation by following established guidelines which are formulated by experts in the field. Supervision must ensure that the guidelines are adhered to.

Criteria

33.3.5.1 The administration of all radio-nuclides for therapy purposes is done by a qualified nuclear medicine physician or radiation oncologist in consultation with a medical physicist and according to statutory radiation safety norms.

33.3.5.2 Where the quantity of radioactive material administered to the patient equals or exceeds 370MBq (10mCi), there is an en-suite ward approved by a medical physicist for the isolation of the patient.

33.3.5.3 If the approved ward is not available, any alternative ward for the isolation of patients is also approved by a medical physicist.

33.3.5.4 A radiation survey of the ward used for the isolation of the patient and adjacent areas is conducted according to the requirements of the medical physicist immediately after the administration of the radioactive material.

33.3.5.5 The isolated patient is monitored regularly during the isolation period and the exposure values are recorded.

33.3.5.6 On discharge of the patient who has been isolated, the ward, the bedding and the bathroom and toilet are monitored according to the requirements of the medical physicist.

33.3.5.7 Orally administered radio-iodine is always in capsule form.

33.3.5.8 A fume hood is used if liquid radio-iodine is being prepared and personnel preparing the radio-iodine are adequately protected.

33.4 Quality improvement

33.4.1 *Quality control procedures are in place, followed and documented.*

Criteria

33.4.1.1 There is a quality control process for the medical physics imaging service, which is implemented.

33.4.1.2 Quality control of radiation treatments and planning are done according to accepted international and local standards. (ICRU, IAEA, etc.)

33.4.1.3 Quality control includes validating test methods.

33.4.1.4 Quality control includes daily surveillance of imaging results.

33.4.1.5 Quality control includes rapid correction when a deficiency is identified.

33.4.1.6 Quality control includes equipment maintenance/testing/safety.

33.4.1.7 Quality control includes documenting results and corrective actions.

33.4.1.8 External audits for quality assurance are utilised to periodically evaluate the medical physics service.

33.4.2 *A formalised proactive quality improvement approach is maintained in the service.*

Criteria

33.4.2.1 There are formalised quality improvement processes for the service, which have been developed and agreed upon by the personnel of the service.

33.4.2.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

33.4.2.3 The quality improvement cycle includes the monitoring and evaluation of the standards set and the remedial action implemented.

33.4.2.4 A documentation audit system is in place.

33.5 Patient rights

33.5.1 *The department/service implements processes that support patient and family rights during care.*

Criteria

33.5.1.1 There are processes which support patient and family rights during care.

33.5.1.2 Measures are taken to protect the patient's privacy, person and possessions.

33.5.1.3 Personnel respect the rights of patients and families to treatment and to refuse treatment.

33.6 Prevention and control of infection

33.6.1 *The department/service implements infection prevention and control processes.*

Criteria

33.6.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

33.6.1.2 Infection control processes include prevention of the spread of infection through invasive devices.

33.7 Risk management

33.7.1 *The department/service implements risk management processes.*

Criteria

33.7.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

33.7.1.2 A system for the monitoring of near misses/adverse events/sentinel events is available, which includes the documentation of interventions and responses to recorded incidents.

33.7.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

33.7.1.4 Fire safety measures are implemented.

33.7.1.5 The hospitals policy on handling, storing and disposing of healthcare waste is implemented.

34 Radiation Oncology

OVERVIEW OF RADIATION ONCOLOGY

Hospitals may provide radiation oncology services as part of an integrated system of services or may have an arrangement with an outside source for the referral of patients.

The selection of an outside source must be based on an acceptable record of accurate, timely service and compliance with Namibian laws and regulations.

Where the hospital provides its own radiation oncology services, these must comply with applicable local and national Namibian standards, laws and regulations.

Radiation safety programmes must be complied with and policies and procedures should be available to guide personnel in the application of safety measures.

34.1 Management of the Service

34.1.1 *A radiation oncology service is provided by the hospital, or is readily available through arrangements with outside sources, to meet the needs of its patient population.*

Standard Intent

The hospital has a system for providing radiation oncology services required by its patient population, clinical services offered and healthcare provider needs. These services, including those required for emergencies, may be provided within the hospital, by agreement with another organisation, or both.

The Radiation Oncology Service should be available after normal hours for emergencies. Outside sources should be convenient for the patient to access and reports should be received in a timely manner, to support continuity of care. The outside source should be selected by the hospital on the recommendation of the director or another individual responsible for radiation oncology services. Outside sources of radiation oncology must meet applicable Namibian laws and regulations and have an acceptable record of accurate, timely service.

Patients should be provided with the complete details of the outside source of radiation oncology service.

Criteria

34.1.1.1 Adequate, convenient and regular radiation oncology services are available to meet needs.

34.1.1.2 An emergency radiation oncology service is available after normal hours.

34.1.1.3 The selection of an outside source is based on an acceptable record of accurate, timely service and compliance with laws and regulations.

34.1.1.4 Patients are informed about any relationships between the referring physician and outside sources of services.

34.1.2 *A qualified individual is responsible for managing the Radiation Oncology Service.*

Standard Intent

The Radiation Oncology Service should be under the direction of an individual who is qualified by virtue of documented training, expertise and experience, in accordance with applicable Namibian laws and regulations. This individual assumes professional responsibility for the Radiation Oncology Service.

The radiation oncology director's responsibilities should include:

- Developing, implementing and maintaining policies and procedures
- Administrative control
- Maintaining any necessary quality control programmes

- Recommending outside sources of radiation oncology services
- Monitoring and reviewing all radiation oncology services

Criteria

34.1.2.1 A radiation oncologist, who is qualified by education, training and experience, manages the service.

34.1.2.2 The responsibilities of this person include developing, implementing and maintaining relevant policies and procedures.

34.1.2.3 The responsibilities of this person include administrative control.

34.1.2.4 The responsibilities of this person include maintaining quality control programmes.

34.1.2.5 The responsibilities of this person include recommending outside sources of radiation oncology services.

34.1.2.6 The responsibilities of this person include monitoring and reviewing all radiation oncology services.

34.1.2.7 There are qualified radiation therapists (radiographers) to provide services in keeping with the scope of their profession.

34.1.2.8 A qualified medical radiation physicist is available to fulfil the legal requirements of the regulations for the safe use of ionising radiation.

34.1.2.9 The service(s) of a legally qualified person(s) is/are available for open and sealed source preparation.

34.1.3 *Personnel are provided with documented policies and guidelines for all aspects of the provision of radiation oncology services.*

Standard Intent

Documented guidelines and policies and procedures are essential to guide personnel in the Radiation Oncology Service in their activities. The existence of documented policies does not preclude modification in the best interests of the patient.

Radiation oncology policies and procedures are related to the requirements or availability of other services in the hospital environment.

Criteria

34.1.3.1 Radiation oncology personnel are orientated to safety procedures and practices.

34.1.3.2 Personnel receive education for new procedures and newly-acquired or recognised hazardous materials and apparatus.

34.1.3.3 The associated medical physicist is involved in the formulation of policies and radiation safety procedures applicable to radiation oncology medicine.

34.1.3.4 Policies and procedures relating to limiting the irradiation of patients and personnel to levels consistent with clinical requirements are implemented.

34.1.3.5 Policies and procedures relating to the conditions under which pregnant women may be subjected to any radiation exposure are implemented.

34.1.3.6 Policies and procedures relating to avoiding radioactive contamination and controlling spread should it occur are implemented.

34.1.3.7 Policies and procedures relating to procedures to be followed in the event of contamination, radiation emergency and overexposure are implemented.

34.1.3.8 Policies and procedures relating to monitoring the hands, clothing and body of every member of personnel leaving a controlled area are implemented.

34.1.3.9 Policies and procedures relating to all trials, clinical or other, involving ionising radiations are implemented.

34.1.3.10 Policies and procedures addressing the handling and disposal of infectious and hazardous materials are implemented.

34.1.3.11 Policies and procedures relating to the reporting of adverse reactions to therapy are implemented.

34.2 Administration of Radiation tests and Treatments

34.2.1 *Individuals with adequate training, skills, orientation and experience administer all tests and treatments.*

Standard Intent

The hospital identifies which members of personnel assess patients, which prescribe and apply treatment and which are responsible for guaranteeing that the prescribed radiation doses are correct. Personnel must have appropriate and adequate training, experience and skills and should be oriented to their work. Personnel must be given work assignments consistent with their training and experience. In addition, sufficient personnel should be available to perform procedures promptly and provide necessary staffing during all hours of operation and for emergencies.

Criteria

34.2.1.1 Diagnostic and therapeutic procedures utilising radiation and/or radiation treatments are planned and performed only upon a formal written prescription from a qualified physician.

34.2.1.2 A radiation oncologist or nuclear medicine physician or a registrar under the supervision of such a physician prescribes and monitors the treatment of the patient.

34.2.1.3 Radiation oncology prescriptions contain relevant clinical information.

34.2.1.4 If all relevant treatment modalities are available, all treatments are initiated as soon as possible.

34.2.1.5 An effective mechanism exists whereby emergency radiation oncology services are initiated promptly.

34.2.1.6 Documents are appropriately filed and distributed.

34.2.1.7 Mechanisms exist whereby records of procedures can be retrieved when necessary.

34.3 Radiation Safety

34.3.1 *A radiation safety programme is in place, is implemented and documented.*

Standard Intent
The hospital must have an active radiation safety programme appropriate to the risks and hazards encountered. The programme must address safety practices and prevention measures for radiation oncology personnel, other personnel and patients. The programme must be coordinated with the hospital's safety management programme.
The radiation safety programme should include:

- Documented policies and procedures that support compliance with applicable Namibian standards, laws and regulations
- Documented policies and procedures for the handling and disposal of infectious and hazardous materials
- The availability of safety protective devices appropriate to the practices and hazards encountered
- The orientation of all radiation oncology personnel to safety procedures and practices

In-service education for new procedures and newly-acquired or recognised hazardous materials

Criteria

34.3.1.1 A qualified medical radiation physicist is available to fulfil the legal requirements of the regulations for the safe use of ionising radiation.

34.3.1.2 A copy of the local rules relating to current ionising radiation regulations is available.

34.3.1.3 A radiation safety programme is in place and is appropriate to the risks and possible hazards encountered.

34.3.1.4 The programme is coordinated with the hospitals risk management programme.

34.3.1.5 Personal dosimeters worn by personnel comply with the ionising radiation regulations.

34.3.1.6 Appropriate radiation safety devices are available.

34.3.1.7 Documented records of radioactive stocks, calculation and preparation, administration and disposal details are maintained.

34.3.1.8 A register of sealed sources is maintained.

34.3.1.9 Facilities for testing the integrity of all sealed sources are available.

34.3.1.10 Contamination monitors and safety mechanisms are available.

34.3.1.11 Area monitors are available where necessary.

34.3.2 *Facilities ensure the safe, efficient and effective functioning of the Radiation Oncology Service.*

Standard Intent
Radiation oncology personnel work with management to ensure that facilities provide for safety and comply with current Namibian radiation (ionising and other hazardous radiations) laws and regulations.

Criteria

34.3.2.1 Facilities ensure that radiation to all personnel is kept as low as possible.

34.3.2.2 Signs warning of the dangers of radiation are prominently displayed.

34.3.2.3 Requirements regarding controlled and supervised areas laid down by the Department of Health or other authority are implemented.

34.3.2.4 A copy of the most recent radiation safety inspection report(s) of department(s) serviced by the radiation oncology department is/(are) held by the person responsible for the department, the Radiation Oncology Department, or the medical physicist.

34.3.2.5 There is a shower available in the event of contamination.

34.3.2.6 Separate toilets for personnel and patients are available.

34.3.3 *All therapy-related equipment is regularly inspected and maintained and appropriate records are kept of these activities.*

Standard Intent
Radiation oncology personnel work with medical equipment management to ensure that all equipment and facilities function at acceptable levels and in a manner that is safe to the operator(s).
A radiation oncology equipment manager programme provides for:

- Selecting and acquiring equipment
- Identifying and taking inventory of equipment
- Assessing equipment use through inspection, testing and maintenance
- Monitoring and acting on equipment hazard notices, recalls, reportable incidents, problems and failures
- Documenting the management programme

Testing and maintenance are related to the use of the equipment and its documented history of service.

Criteria

34.3.3.1 Policies and procedures relating to radiation oncology equipment safety and management complying with current applicable legislation and standards are implemented.

34.3.3.2 There is a medical equipment management programme which includes selecting and maintaining the equipment.

34.3.3.3 The programme includes taking an inventory of equipment.

34.3.3.4 The programme includes the inspecting, testing, quality control and continuous monitoring of equipment.

34.3.3.5 The programme ensures that all equipment used complies with the regulations and requirements of the Radiation Authorities including regular and recorded calibration of all radiation monitoring equipment.

34.3.3.6 Radiation monitors are calibrated regularly.

34.3.3.7 Values are recorded in a log book.

34.3.3.8 There is documentation of all testing, maintenance and calibration of equipment.

34.3.3.9 All linear accelerators are calibrated and subjected to a constancy output on a regular and frequent basis.

34.3.3.10 All equipment is checked on a daily basis.

34.3.3.11 The accuracy of the computer control of all 'After Loading High Dose Rate' units is checked at regular intervals and the results recorded.

34.3.4 *Radioactive materials (open and sealed sources) intended for administration to, or implantation into, patients are prepared in a manner which satisfies both radiation safety and pharmaceutical quality requirements.*

Standard Intent

Sound quality control systems are essential to providing excellent radiation oncology services. Quality control procedures should include:

- Validation of the procedures used
- Regular and frequent surveillance of results by a medical physicist
- Rapid corrective action when a deficiency is identified

Documentation of results and corrective actions

Criteria

34.3.4.1 Appropriate aseptic precautions are implemented for each application.

34.3.4.2 The radio-pharmacy is designed to ensure the history of each radio-pharmaceutical dose can be traced.

34.3.4.3 Radio-pharmaceuticals and radioactive implants are only dispensed or prepared on the written request of a qualified medical practitioner.

34.3.4.4 Each preparation of sealed sources is recorded with the dose plan, calculations and all relevant details.

34.3.4.5 All containers with radioactivity are labelled according to specifications, stating that the contents are radioactive and indicating the radio-nuclide, the activity and the date.

34.3.5 *The management of organ disease using radionuclides is practised taking into account the safety and well-being of patients and personnel as a consequence of the high radiation levels.*

Standard Intent
Where open radionuclides are used, all personnel and patients in the hospital must be protected from exposure to radiation by following established guidelines, which have been formulated by experts in the field. Supervision must ensure that the guidelines are adhered to.

Criteria

34.3.5.1 The administration of all radionuclides for therapy purposes is done by a qualified nuclear medicine.

34.3.5.2 physician or radiation oncologist in consultation with a medical physicist and according to statutory radiation safety norms.

34.3.5.3 Where radioactive material administered to the patient equals or exceeds a level of 370MBq (10mCi), it is administered by the radiation oncologist only.

34.3.5.4 Where radioactive material administered to the patient equals or exceeds a level of 370MBq (10mCi), there is an en-suite ward approved by the medical physicist for isolation of the patient.

34.3.5.5 In the event that the approved ward is not available, any alternative ward for isolation of the patient is also approved by the medical physicist.

34.3.5.6 A radiation survey of the ward used for isolation of the patient and adjacent areas is conducted according to the requirements of the physicist immediately after administration of the radioactive material.

34.3.5.7 The isolated patient is monitored regularly during the isolation period and exposure values are recorded.

34.3.5.8 On discharge of the patient who has been isolated, the ward, the bedding and the bathroom are monitored according to the requirements of the physicist.

34.3.5.9 Orally administered radio-iodine 10mCi and above is always in capsule form.

34.3.5.10 Open source nuclides by injection are administered only by the radiation oncologist.

34.3.5.11 A fume hood is used if liquid radio-iodine is being prepared and the personnel preparing the radioiodine are adequately protected.

34.3.5.12 Administration of all radionuclides for therapy purposes is done in consultation with the physicist and according to statutory radiation safety norms.

34.4 Quality Improvement

34.4.1 *Quality control procedures are in place, followed and documented.*

Standard Intent

It is the responsibility of the management of the service to ensure that standards are set. This requires coordination with the hospital's quality improvement committee. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.
Sound quality control systems are essential to providing excellent radiation oncology services. Quality control procedures should include:

- Validation of the test methods used for accuracy and precision
- Daily surveillance of results by qualified radiation oncology personnel
- Rapid corrective action when a deficiency is identified

Documentation of results and corrective actions

Criteria

34.4.1.1 Documented quality improvement and control processes for the Radiation Oncology Service are implemented.

34.4.1.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

34.4.1.3 Quality control of radiation treatments and planning are done according to accepted international and local standards, (ICRU, IAEA, etc.).

34.4.1.4 Quality control includes validating test methods.

34.4.1.5 Quality control includes daily surveillance of imaging results.

34.4.1.6 Quality control includes documenting results of rapid corrective actions when a deficiency is identified.

34.4.1.7 Quality control includes equipment maintenance/testing/safety.

34.4.1.8 External audits for quality assurance are used periodically to evaluate the Radiation Oncology Service.

34.4.2 *A formalised proactive quality improvement approach is maintained in the service.*

Standard Intent
This refers to the implementation of hospital quality improvement processes (Service Element 7). It is the responsibility of management of the hospital to ensure that standards are set throughout the hospital. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the hospital's central coordinating quality improvement structures or systems. Departmental managers should use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

- Request forms without history or clinical diagnosis
- Number of unidentified patients
- Unescorted patients arriving at the department
- Waiting times
- Patient and family expectations and satisfaction. The following will be evaluated:
- Problems identified in this service for which quality improvement activities were initiated
- The processes put in place to resolve the problems
- The identification of indicators to measure improvement
- The tool(s) used to evaluate these indicators

- The monitoring of these indicators and corrective steps taken when goals were not achieved
- Graphed and/or tabled results, as appropriate

A once-off project such as acquiring a specific item of equipment will be scored NC.
Quality improvement processes not related to the clinical quality of patient care, but to the environment within which care is provided, for example monitoring the checking of emergency trolley over time, will be scored PC.

Criteria

34.4.2.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

34.4.2.2 Indicators of performance are identified to evaluate the quality of treatment and patient care.

34.4.2.3 The quality improvement cycle includes the monitoring and evaluation of the standards set and the remedial action implemented.

34.4.2.4 A documentation audit system is in place.

34.5 Patient Rights

34.5.1 *The department/service implements processes that support patient and family rights during care.*

Standard Intent
This refers to the implementation of hospital policies on patient and family rights (Service Element 4). Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

Criteria

34.5.1.1 There are processes that support patient and family rights during care.

34.5.1.2 Measures are taken to protect the patient's privacy, person and possessions.

34.5.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

34.6 Prevention and Control of Infection

34.6.1 *The department/service implements infection prevention and control processes.*

Standard Intent
This refers to the implementation of hospital processes for infection prevention and control (Service Element 8).

Criteria

34.6.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

34.6.1.2 Infection control processes include prevention of the spread of infection through intravascular invasive devices.

34.7 Risk Management

34.7.1 *The department/service implements risk management processes.*

Standard Intent
This refers to the implementation of hospital risk management processes (Service Element 5).
The hospital must have an active radiation safety programme that includes all components of the hospital's services including medical physics, radiation oncology and the cardiac catheterisation laboratory. The radiation safety programme must reflect the risks and hazards encountered. The programme must address safety practices and prevention measures for other personnel and patients. The programme must be coordinated with the hospital's safety management programme.

Criteria

34.7.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of hospital risk management processes.

34.7.1.2 A system for the monitoring of near misses/adverse events/sentinel events is available, which includes the documentation of interventions and responses to recorded incidents.

34.7.1.3 Security measures are in place and implemented for the safeguarding and protection of patients, personnel and visitors.

34.7.1.4 Fire safety measures are implemented.

34.7.1.5 The hospitals policy on handling, storing and disposing of healthcare waste is implemented.

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