Republic of Botswana

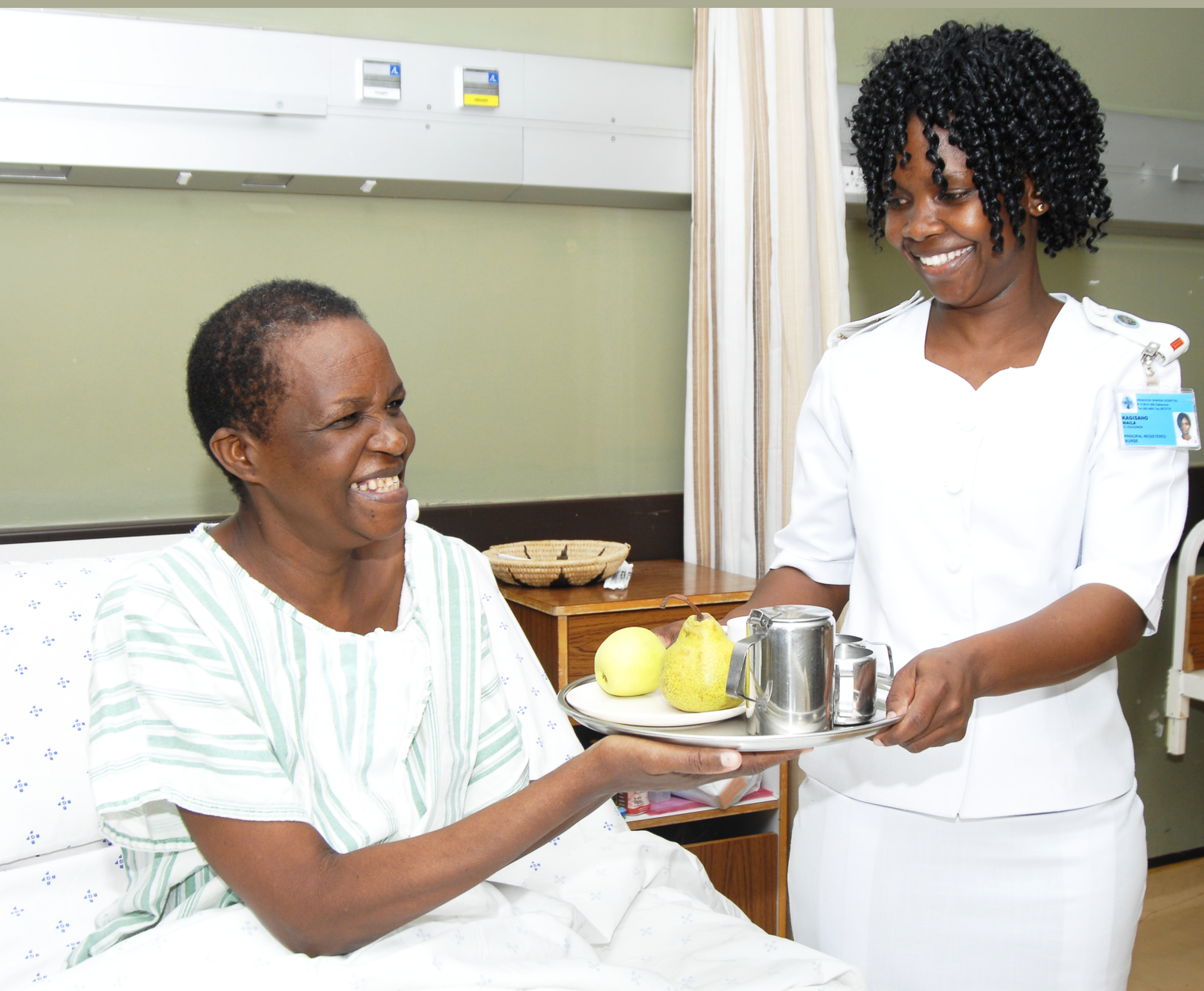
National Health Quality Standards

Standards & Guidelines for Hospitals

"Ancillary and Occupational Services"

Volume 3

Improving Quality & Safety of Health Services



National Health Quality Standards

Standards & Guidelines
For Hospital Standards
Volume 3

Ministry of Health Headquarters
Private Bag 0038
Plot 54609
Government Enclave
Gaborone
Botswana

Tel: (+267) 363 2602
(+267) 363 2500

Fax: (+267) 397 4512

Website: moh.gov.bw

TABLE OF CONTENTS

SE 27 LINEN MANAGEMENT

SE 28 HOUSEKEEPING SERVICE

SE 29 MAINTENANCE SERVICE

SE 30 RESUSCITATION SYSTEM

SE 31 MEDICAL EQUIPMENT MANAGEMENT SERVICE

ABBREVIATIONS

ADR	Adverse Drug Reaction
AED	Automated External Defibrillator
BCA	Biological and Chemical Agents
BHPC	Botswana Health Professions Council
BLS	Basic Life Support
BNF	British National Formulary
CAT	Computerized axial tomography
CCTV	Closed-circuit television
CD	Compact Disc
CED	Clinical Engineering Department
COHSASA	Council for Health Service Accreditation of Southern Africa
CSSD	Central Sterilizing and Supply Department
CPR	Cardio-Pulmonary Resuscitation
DAP	Dose Area Product
DNA	Deoxyribonucleic acid
ECG	Electrocardiography
ECT	Electro Convulsive Therapy
EDL	Essential Drug List
EMS	Emergency Medical Services
ESE	Entrance Skin Exposure
ETT	Endotracheal Tube
GCS	Glasgow Coma Scale
HEPA	High-Efficiency Particulate Air
HCW	Healthcare Waste
HIV	Human Immunodeficiency Virus
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IEC	Information Electrotechnical Commission
ISO	International Organization for Standardization
ISQua	International Society for Quality in Health Care
JCI	Joint Commission International
MEMS	Medical Equipment Management Services
MET	Medical Emergency Team
MI	Myocardial Infarction
MIGB	Metaiodobenzylguanidine
MIMS	Monthly Index of Medical Speciality
MVA	Motor Vehicle Accident
QM&I	Quality Management and Improvement
RRSs	Rapid Response Systems
SANF	South African Nature Foundation
SDU	Sterilizing and Disinfecting Unit
TB	Tuberculosis
UPS	Uninterruptable Power Supply
VIE	Vacuum Insulated Evaporator
VIP	Very Important Person
WHO	World Health Organization

Foreword

The Government of Botswana and independent medical institutions have since independence managed to build healthcare facilities of different capacities delivering healthcare services at different levels of care. The adoption of the Primary Healthcare strategy has critically influenced the development of public healthcare facilities to be in areas within reach of every citizen. This has always been a good development pertaining to access to healthcare by the people of this country.

Notwithstanding the above, there have been some major challenges faced by our health system, one which is provision of quality and safe healthcare services. People are no longer complaining of lack of hospitals and clinics but rather of the quality and safety of service they receive. The National Healthcare Service Standards represents a new era in the way we provide healthcare and are aimed at propelling us to greater heights in meeting the needs and expectations of our clients and the public at large. They set out basic requirements that will promote delivery of services based on shared values, and also establish the basis for continuous improvement of the quality and safety of the patient care. The standards will not only provide a framework for self assessment and for external review and investigation, but would also enhance the reputation and credibility of our healthcare system. Their implementation framework provides an execution strategy or road map to realize this.

These National Healthcare Service Standards have been designed in such a way that they can be implemented in all types of healthcare services or settings. They provide the foundation which is applicable to the full spectrum of patient care for the various levels of care in an organization as a whole and to specific areas as appropriate.

I urge all providers to use them to strive to continuously improve the quality and safety of care. May I kindly underscore that successful implementation of the standards requires all healthcare organisations whether in Government and private sector to take account of the quality and safety of all their services. They should conduct self-assessments against the standards and manage their performance. It is envisaged that all healthcare service providers will be subjected to compliance with the standards once the legislation is put in place. I therefore urge all providers to adopt the standards in advance of the proposed legislation. Progress by healthcare organisations to achieve compliance against these standards will be assessed through independent inspections and audits.

I am confident that their implementation will build on the improvements achieved this far and will serve as a catalyst for a change to a culture of continuous improvement that puts the patients at the forefront so that we are able to provide the right care for the right person at the right time, the first time.

Rev. Dr. John G.N. Seakgosing
Minister of Health

Acknowledgements

The National Health Quality Standards are a product of various stakeholders drawn from different disciplines from both Government and private sector and other interested stakeholders. The Ministry of Health acknowledges enormous support from the Council for Health Service Accreditation of Southern Africa (COHSASA) who through their expertise and advice has made the development of the National Health Quality Standards a reality.

Our sincere thanks to the general public and various stakeholders with vested interest in health for their valuable inputs and comments; and management and staff of Athone Hospital for allowing us to use their facility as a pilot test site for the Hospital Standards.

Lastly, let me be mindful of the fact that health is dynamic and assure you that the Government is committed to ensure that these standards remain relevant and the Ministry will be thankful to all stakeholders to be involved in their continuous monitoring and future reviews.

Dr. K. Seipone
Director Health Services

DEFINITION OF TERMS

Acceptability	Acknowledgement that the reasonable expectations of the patient, funders and the community have been satisfied.
Accessibility	Means that access to health 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 organisation is in compliance with applicable predetermined standards. (See also *certification, licensure.)*
Adverse event	An adverse event may be defined as any event or circumstance arising during a stay in a clinic/health centre 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.
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	Health services that do not require the hospitalisation of a patient, such as those delivered at a physician's office, clinic and casualty or outpatient facility.
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 client's needs.
Assessment	Process by which the characteristics and needs of clients, 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

organisation'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 organisation 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 health 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 (e.g. parasites, viruses, bacteria, fungi, prions, rickettsias), 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 closed-chest cardiac massage.
Carer	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, e.g. a medical specialist, whereas accreditation is applied only to institutions or programmes, e.g. a clinic/health centre 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 health session in a health setting. 2. A defined health 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 health workers who are registered/enrolled with a professional body, and who are involved in the care of clients/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.
Clinical privileges	Authorisation granted by the governing body to clinical personnel to provide specific patient care services in the organisation within defined limits, based on an individual practitioner's registration,

	education, training, experience, competence, health status and judgement. (See also *privileging*.)
Clinical waste	Clinical waste is waste arising from medical, dental or veterinary practice or research, which has the potential to transmit infection. Other hazardous waste, such as chemical or radioactive, may be included in clinical waste, as well as waste such as human tissues, which requires special disposal for aesthetic reasons.
Community	A collection of individuals, families, groups and organisations that interact with one another, cooperate in common activities and 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.
complaince survey	An external evaluation of an organisation to assess its level of compliance with standards and to make determinations regarding its compliance 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 on-site observations by surveyors.
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 client service delivered by the organisation 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 health facility) and the provider of the service (the external company).
Contracted service	A service that is obtained by the organisation through a contract with an agency or business. The contracted service is monitored and coordinated by the organisation's staff and complies with national regulations and organisational policies.
Credentialing	The process of obtaining and reviewing the clinical training, experience, certification and registration of a health professional to ensure that competence is maintained and consistent with privileges.
Criterion	A descriptive statement that is measurable and that 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 it is for a given time span.
(b) Comparative data	When a data set is compared with like data sets or with a given time, usually of the previous month or year.
Data retention	Guidelines on how long an organisation 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 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 includes: • the reason for admission • significant findings • final diagnosis • the results of investigations that will influence further management • all procedures performed • medications and treatments administered • the patient's condition at discharge • discharge medications and follow-up instructions.
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 clinic/health centre or staff with a director, manager or other designated person in charge. May be a professional service, such as nursing or surgery, a professional support service, e.g. radiology or physiotherapy, a general support system such as administration or health record system, a committee to guide aspects of the service, e.g. health and safety, or a community health service.
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.
Facility	The health centre, general practice or any other site providing a health service.
Food handler	Persons who in the course of their normal routine work come into contact with uncovered food not intended for their personal use. Food includes water

	and any other liquid intended for human consumption. A food handler is thus any person involved in the processing, production, manufacturing, packaging, preparation, sale or serving of any foodstuff, including water and beverages.
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 organisation's direction, setting objectives and developing policy to guide the organisation 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 organisation, also known as the council, board, etc.
Guidelines	Principles guiding or directing action.
Health	A state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity.
Health worker	A health worker/provider is an individual who provides preventive, curative, promotional or rehabilitative health services in a systematic way to individuals, families or communities. An individual health worker/provider may be a health professional within medicine, nursing, or a field of allied health. Health service providers may also be a public/community health professional.
Health facility category	The category that indicates the level of care provided by the facility as defined in the accompanying Health Facility Category document.
Health professionals	Medical, nursing or allied health professional personnel who provide clinical treatment and care to clients, 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 to 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.
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 clinic/health centre. The health summary will quickly and accurately inform the staff at the clinic/health centre of the condition and treatment the patient received at the previous visit.
High-risk	Refers to aspects of service delivery which, if incorrect, will place clients at risk or deprive them of substantial benefit.
High-volume	Refers to aspects of service delivery that occur frequently or affect large numbers of clients.
Human resource planning	Process designed to ensure that the personnel needs of the organisation will be constantly and appropriately met. Such planning is accomplished through the analysis of internal factors such as current and expected skill needs, vacancies, service expansions and reductions, and factors in the external environment such as the labour market.
Implementation	The delivery of planned health.
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 clinic/health centre in the event of a major national or local disaster that may affect the health of many people. The plan is 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 clinic/health centre that affects the health or safety of patients and staff, such as fire, bomb threats, explosions or loss of vital services.
Incidents	Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on clients, groups, staff or the organisation.
Indicator	1. A measure used to determine, over time, performance of functions, systems or processes.

2. A statistical value that provides an indication of the condition or direction, over time, or performance of a defined process, or achievement of a defined outcome.

3. The measurement of a specific activity that is being carried out in a health setting, e.g. weight for age is a measurement of a child's nutritional status.

Induction programme	Learning activities designed to enable newly appointed staff 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 an organisation-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 the guardian 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 staff must confirm that the patient or guardian 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/guardian should refuse the procedure/treatment, the consequences of such a decision should be made clear and, if a second opinion is sought, the patient/guardian should be apprised of the consequences of the delay and be assisted in obtaining 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 organisation's staff members or teach them new skills relevant to their responsibilities and disciplines. Usually provided in-house i.e. at the place of employment.
Job 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 an organisation.
Leader	A person providing direction, guidance, regulation or control. A person followed by others.
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 governmental authority grants a health organisation permission to operate following an on-site inspection to determine whether minimum health and safety standards have been met.
Manager	An individual who is in charge of a certain group of tasks, or a certain section of an organisation. A manager often has a staff of people who report to him or her. Synonyms: director, executive, head, supervisor, overseer, foreman.
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 organisation, staffing, controlling and problem solving.
Mechanism	The mode of operation of a process or a system of mutually adapted parts working together.
Medical practitioner	Registered medical practitioners are medical doctors with a medical degree registered as medical practitioners in the country they practice in by the statutory registration authority of that country. A general practitioner (GP) is a medical practitioner who treats acute and chronic illnesses and provides preventive care and health education for all ages and all sexes. They have particular skills in treating people with multiple health issues and comorbidities. The word physician is largely reserved for certain other types of medical specialists, notably in internal

	medicine. A physician is a health service provider who practices the profession of medicine, which is concerned with promoting, maintaining or restoring human health through the study, diagnosis, and treatment of disease, injury and other physical and mental impairments. They may focus their practice on certain disease categories, types of patients or methods of treatment – known as specialist medical practitioners. Both the role of the physician and the meaning of the word itself vary around the world, including a wide variety of qualifications and degrees.
Mission statement	A statement that captures an organisation's purpose, customer orientation and business philosophy.
Monitoring	A process of recording observations of some form of activity.
Monitoring and evaluation	A process designed to help organisations effectively use their quality assessment and improvement resources by focusing on high-priority, quality-of-care issues. The process includes: identifying the most important aspects of the care that the organisation (or department/service) provides by 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 of 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 organisation 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 organisation.
Outcome	Refers to the results of the health service 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 staff member review the staff member's performance, set performance goals and evaluate progress towards these goals.
Performance measure	A quantitative tool or instrument that provides an indication of an organisation's performance regarding a specified process or outcome.
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 an organisation's mission and determining appropriate goals and objectives to implement the mission.
Policy	Written statements that act as guidelines and reflect the position and values of the organisation on a given subject.

Practice	Partners in a professional practice, employed personnel and their patients/ clients.
Primary Healthcare	The first level of contact of individuals, the family and community with the public health system, bringing health services as close as possible to where people live and work. Primary Healthcare includes health education, promotion of proper nutrition, maternal and child health (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 staff, 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 policy.
Process	A sequence of steps through which inputs (from health facilities) are converted into outputs (for patients).
Professional registration	Registration in terms of current legislation pertaining to the profession concerned.
Professional staff	Staff 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 practice, and/or staff who exercise independent judgment in decisions affecting the service delivered to clients.
Professional team	A number of health professionals whose functions are interdependent. They work together for the care and treatment of a specific patient or group of patients.
Protocol	A formal statement. May include written policies, procedures or guidelines.
Quality	Degree of excellence. The extent to which an organisation meets clients' 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 control	The monitoring of output to check if it conforms to specifications or requirements and action taken to rectify the output. It ensures safety, transfer of accurate information, accuracy of procedures and

	reproducibility.
Quality improvement	The actions undertaken throughout the organisation to increase the effectiveness and efficiency of activities and processes, in order to bring added benefits to both the organisation and its customers.
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 organisation 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 staff. 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 accurately and consistently identify the events it was designed to identify across multiple health 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 client, staff member, physician, volunteer, reputation, net income, property or liability of the organisation.
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 organisation in accordance with

	relevant legislation.
Safety	The degree to which potential risks and unintended results associated with health are avoided or minimised.
Seamless continuum of care	In the ideal health system, care is delivered in an integrated, uninterrupted or 'seamless' flow. It is defined as an integrated, client oriented system of care composed of both services and integrating mechanisms that guides and tracks clients over time through a comprehensive array of health, mental health and social services spanning all levels of intensity of care.
Setting	The particular health 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.
Staff	All individuals employed by the facility – this includes full time, part time, casual or contract, clinical and non-clinical personnel.
Staff development	The formal and informal learning activities that contribute to personal and professional growth, encompassing induction, in-service 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.
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, patient-centred	For the purposes of compliance, standards that address and are organised around what is done directly or indirectly, for or to patients (e.g. creation of patient records, patient assessment).
Standards-based evaluation	An assessment process that determines a health organisation's or practitioner's compliance with pre-established standards.
Step-down facility	The Joint Commission (*Survey Protocol for Sub-acute Programmes,* 1995) defines a step-down unit as follows: **"**At the most complex end (of a range of sub-acute care services) are the short stay, transitional step-down units, which are often, but not always, attached to clinic/health centres. These units provide a substitute for continued clinic/health centre 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 *sub-acute care centre*).
Structure	The physical and human resources of an organisation.
Sub-acute care centre	The Joint Commission *(Survey Protocol for Sub-acute Programmes,* 1995) defines sub-acute care as follows: Sub-acute 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 health professional who meets health quality surveyor selection criteria, evaluates standard compliance and provides consultation regarding standard compliance to surveyed organisations.

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 self-managed teams. (See also *multidisciplinary team* and *professional team*.)
Timeliness	The degree to which care is provided to the patient at the most beneficial or necessary time.
User	Someone who uses or could use the services offered by the facility.
Utilisation management	Proactive process by which an organisation 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* (pre-admission certification) – The purpose is to assess whether hospitalisation has been justified, and is diagnosis-independent. *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 clinic/health centre or any patient who has received ambulatory care.
Validation of survey	A process whereby a facilitator assesses the completed self-assessment documents of a facility. The validation ensures that criteria have been correctly interpreted and 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 organisation intends to become and to achieve at some point in the future.
Waste management	Collection, treatment, storage, transportation and disposal of waste material including biomedical, household, clinical, confidential and other waste.

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

INTRODUCTION

HOSPITAL STANDARDS

This manual contains National Health Quality Standards for hospital services and includes guidelines for their consistent interpretation and accurate assessment.

The purpose of this manual is to serve as a guide to surveyors and facilitators, as well as environmental health staff. 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.

These standards are a result of an initiative by the Ministry of Health to develop standards for healthcare facilities at all levels.

In order to plan a system the capabilities of individual organisations 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 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.

It is recognised that some institutions in the country start from a deprived base, and that officers may feel that the gap between the actual situation and the standards is so great that it is not worth trying to bridge it. However, standards should not be written to fit current circumstances and in situations where bringing services up to compliance level is a daunting prospect, a graded recognition programme is appropriate, where credit and certification is given for progress towards accreditation.

A: Structure/Format

This set of standards consists of several Service Elements (SE's) for the various services/departments. Each Service Element contains the relevant standards and criteria (measurable elements) to be assessed in order to ascertain the level of compliance with the standards.

The first nine Service Elements, i.e. SE 1 to SE 9, are referred to as the "generic" service elements as their requirements apply across the entire hospital. The same principle applies to Service Elements 28, 29, 30 and 31.

Information on the standards in this document has been set out in the following format and the first section of Service Element 1 - *Management and Leadership* - is used as an example to demonstrate the layout:

1 MANAGEMENT AND LEADERSHIP

OVERVIEW OF MANAGEMENT AND LEADERSHIP

Providing excellent patient care requires effective management and leadership, which occur at various levels in a healthcare organisation. At the governance level there is an entity.

1.1 Governance of the organisation

1.1.1 The responsibilities and accountability of the governance of the organisation are documented and implemented by the organisation's managers.

Intent of 1.1.1
There is a governing body responsible for directing the operation of the organisation, which is accountable for providing quality healthcare services to its community.

1.1.1 Criteria

1.1.1.1 The organisation's governance structure is described in written documents, which are known to the staff in the organisation.

Guideline: This Governance structure refers to the authority(ies) above the level of the Facility Manager and may include National//Regional/District levels in the Public Sector together with the Hospital Board, or Corporate structures in the.

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:	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 organisation	The first "performance indicator" (or main section) for this service element.
1.1.1 The responsibilities and accountability of the governance of the organisation are documented and implemented by the organisation's managers	The first standard in this service element.
Intent of 1.1.1	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.
1.1.1 Criteria	This heading indicates that what follows is the

	list of criteria (measurable items) that support standard 1.1.1
1.1.1.1 The organisation's governance structure is described in written documents, which are known to the staff in the organisation	The first criterion in this section for standard 1.1.1
Guideline	*A description/explanation of what is expected and guidance on how to assess compliance with the criterion.*

B: Additional Notes on the "Guidelines" (section in italics below the criteria in the above example)

Purpose/intention of the guideline statements*:*
The purpose of these guidelines is to provide guidance on the scope and interpretation of the criteria statements. The information should also provide facility staff (clients) with a clear indication of the requirements for compliance and some direction on the assessors' expectations.

In some instances the guidelines also state the minimum requirements for compliance and provide direction on how to reach a decision on the compliance score.

Linked criteria/standards:
Where the comment "*Linked to:"* appears in the guideline text box, it refers to other criteria and standards that are linked to the criterion being assessed. For further information on how to deal with these linked criteria, refer to item 7 in section C ("Rules for scoring") of this document.

Root criterion
Where the guideline text box contains the word "root criterion", the following applies:

- A "root" criterion is considered to be the central focus of a process or system, which is supported by several other "sub-criteria" that intend to describe the smaller components of such a system or process.
- The rating of a root criterion is dependent on the compliance rating of its supporting criteria, and should, therefore reflect the aggregated average of the scores of such supporting criteria.
- This implies that a root criterion cannot be scored until such time that all its linked criteria have been assessed.

For more details on the scoring methodology for root criteria and their links, refer to item 7 in section C below.

C: Rules for assessment of compliance with criteria and the scoring system

The standards in this manual are written expectations of structures, processes or performance outcomes and it is assumed that, if these standards are met, better services/care can be delivered The standards in turn are defined by objective, measurable elements referred to as "criteria".

Criteria are given weighted values (severity ratings) according to how important the criterion requirement is in relation to various aspects (categories) such as legality, patient and staff safety, physical structure, operational effectiveness and efficiency.

Take note that assessing compliance with the standards and criteria includes various activities such as studying documentation, staff and patient interviews, patient record audits and observation of patient care processes, 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:

1. ***Compliant (C)*** means the condition required is met. Evidence of compliance should be present in a tangible and/or observable form, e.g. written material, physical items, etc.

   1.1 Should the standards, for example, require a **written** policy and procedure but the facility has only a verbal policy in place, then the criterion should be scored as ***non compliant***

   1.2 Should the facility have a written policy 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 ***policies, procedures, programmes, plans, protocols, guidelines, etc.***

2. ***Partially compliant (PC)*** means the condition required is not totally met, but there is definite progress (>50%) towards compliance *and the deficiency does not seriously compromise the standard.* Other considerations for PC ratings are:
   2.1 If the criterion requires a documented system as listed above, but there is no implementation or implementation is partial; or if the policy document is still in draft form.

   2.2 If the criterion contains more than one requirement, e.g.: "There is a policy and procedure on the *safe prescribing, ordering and administration* of medicines," but not all components are compliant.

   2.3 If assessment results can be quantified by means of conducting an audit, e.g.: "less than 80% of staff have received training", or "evidence was found in less than 80% of patient records audited".

   2.4 Since there are degrees of partial compliance (PC), the category PC is further subdivided into four degrees of severity: *mild (1), moderate (2), serious (3) and very serious (4)*. These can be thought of as being 80% towards compliance, 60% towards

compliance, 40% towards compliance and 20% towards compliance. Obviously, the further away from compliance, the more severe the deficiency will be.

3. ***Non-compliant (NC)*** means there is no observable progress towards complying with the required condition. The degree of non-compliance is again scored in terms of severity, from mild (1) to very serious (4), as explained above.

4. ***Not applicable (NA)*** means the criterion is not applicable because the facility either does not provide the service at all, or not at the particular level the criterion is designed to measure. Such criteria are excluded in calculating compliance scores.

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

Rating	**Score**
C	80
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

6. **Critical criteria**

A standard may have one or more criteria that are marked "critical". This is where non- or partial compliance will compromise patient or staff safety, or where there are legal transgressions.

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 staff safety, is in direct contravention of an act or regulation, severely affects patient care or the efficiency of the facility, then it must be scored as NC. [e.g. 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.

7. **Scoring "linked" criteria**

Several criteria (either in the same SE or in different SEs) are linked with one another, either because they deal with the same system or process, or because they are duplications, or because one of the criteria may be seen as the "root" with several other criteria focussing on "sub-components" of such a "root" criterion. Should such a linked criterion be scored NC or PC, then this *may have* an impact on the compliance ratings of other linked criteria. The following rules should be applied when scoring linked criteria:

7.1 If a ***critical*** criterion scores NC or PC, then *selected* linked criteria should reflect a similar score.

7.2 Also, if a substantial number of ***non-critical*** criteria linked to a critical criterion score NC or PC, the critical criterion should reflect a similar score.

7.3 The same rule applies to criteria that relate to ***legal*** requirements and patient/staff ***safety*** matters.

The decision to apply the above will depend on the local circumstances and the consideration of the following additional rules.

7.4 If the majority of criteria that focus on the same system or process are scored either NC or PC, then the root criterion should reflect a similar score (because this would constitute a ***high-volume*** deficiency) Example: if ***most*** of the policies and procedures in the organisation have not been reviewed, then the root criterion (1.2.4.5) is scored NC.

7.5 <u>Example of linked criteria</u>:

Criterion 1.2.8.10: The organisation's structure and processes support monitoring of the quality of clinical services.

Criterion 8.1.1.1: There is a relevant and appropriate system/mechanism for the execution/implementation of a quality management and improvement programme.

Criterion 8.2.1.1: Clinical staff identify key measures to monitor clinical areas.

Criterion10.8.1.1:There is a written quality improvement programme for the service that is developed and agreed upon by the personnel of the service.

Criterion10.8.1.3:Indicators of performance are identified to evaluate the quality of treatment and patient care.

In the above example, criterion 1.2.8.10 is the ***root criterion*** for the entire organisation, and cannot be scored compliant unless most of the other linked criteria are also compliant. In the same way, criterion 8.1.1.1 is the ***root criterion*** for all quality improvement programmes and cannot be compliant unless there are programmes in operation in the majority of the departments and services (refer to 10.8.1.1 and similar criteria in other Service Elements).

D: The Matrix Model

As explained above, the structure of the standards and criteria is such that many of these are "interlinked", either within the same Service Element or between the different Service Elements. "Interlinked" means that the same standard/criterion is either repeated in more than one location, or that the standard/criterion is similar to, or closely linked to another standard/criterion in terms of its meaning or in terms of the system or process that it measured.

In using the matrix (refer to the separate Matrix document), scoring rules should apply as indicated in subparagraphs 7.1 to 7.5 above.

The matrix document that is supplied has a section for each service element and should be interpreted as follows:

1. The first column (to the left) lists those criteria for the particular Service Element that have associated links in other Service Elements – such links are displayed (in the rows) for the respective Service Elements.

E: Patient Record Audit

There are several criteria in the various clinical Service Elements related to the content of patient records. Such criteria are identified with the words ***patient record audit*** in the guideline statements. In order to assess compliance with these, a structured documentation audit needs to be conducted on a representative sample of patient records from all the clinical services/departments that are being assessed. Relevant criterion numbers are also listed in the guideline for the particular service element - refer to the guideline for 10.8.1.6 as an example.

Documentation audit tools have been designed for each clinical Service Element, which contain all criteria that relate to the content of patient records. See the example below of the extract from an audit tool (for Service Element 10) used by assessors. The average result obtained for each criterion is transferred to the Standard Assessment Manual as the final assessment score. (If the patient record under review is not expected to reflect information as required by the criterion being assessed, such a criterion is scored NA).

Health records/folders of discharged patients are audited for this purpose. Surveyors select patient folder numbers from admission registers in the various clinical departments in the hospital, including outpatient, emergency (casualty) and professional service settings. The reason for admission/diagnosis of the patient forms the basis of this selection and surveyors attempt to include in the selection folders that may also contain information on aspects such as:

1. Internal transfers/admissions
2. External transfers
3. Blood transfusions
4. Nutrition therapy
5. Resuscitation
6. Informed consent

7. Absconding
8. Refusing hospital treatment (RHT)
9. Resuscitation
10. Death

During an audit survey, the assessors conduct this patient record audit before they have a group interview with clinical staff, during which they share these audit results with staff. These audit results can therefore not be changed when surveyors browse through active records during subsequent visits to the clinical wards. Also, these results cannot be changed post survey if the hospital presents progress reports on improvements with regard to remedial actions in this regard.

Assessors are obliged to sign a Declaration of Confidentiality on appointment and they are expected to maintain the highest level of confidentiality in their handling of patient folders and dealing with patient health information.

Extract from Patient Record Audit Tool

4. Whenever the mix contains 2 x or 3 x C's: percentage of C's is either 40 or 60%, therefore score as PC with comment "Evident in less than 80% of files audited.
5.If mix contains either 1x C or **no** C's: if equal distribution of NC's and PC's, record average as PC, with comment as above. If unequal distribution, average score same as most frequent r
6. Any score of NA is ignored and calculations adjusted accordingly.

Patient file number	Patient file number	Patient file number	Patient file number	Patient file number	Average	SE 10: Medical/Surgical/Paediatrics/Obstetrics	
						Std.10.1.2: The delivery of services is integrated and co-ordinated amongst care	
NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C		**10.1.2.3**	The records are up to date to ensure the transfer of the latest information.
						10.1.2.4	Information exchanged includes:
NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C			the patient's health status,
NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C		**10.1.2.5**	summary of the care provided,
NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C		**10.1.2.6**	the patient's progress.
NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C		**10.1.2.7**	The author can be identified for each patient record entry
NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C		**10.1.2.8**	The date of each patient record entry can be identified
						Std. 10.2.1: All patients cared for have their health care needs identified throu	
NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C		**10.2.1.2**	Only those individuals permitted by applicable laws and regulations or by reg
						Std. 10.2.2: Clinical practice guidelines are used to guide patient assessment	
NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C	NA NC ***PC*** C		**10.2.2.3**	The maternal and foetal conditions and progress of labour are recorded on a
						Std.10.2.3: Assessments are performed within appropriate time frames.	
						10.2.3.1	Written procedures ensure that assessments are performed within appropriat

F: Patient Interviews

The standards contain several criteria that relate to patient rights, patients' experiences while being attended to in a health care facility, the extent to which patients are informed about relevant matters, etc. For some of these criteria, evidence of compliance can only be obtained from the patients' responses and for that reason these criteria have been included in a patient questionnaire which the surveyors will administer in clinical areas of the hospital during the survey.

Below is an extract of the questionnaire. Responses from the patients are scored similarly to those for the patient record audit process described above and the average score of each criterion is transferred to the Standard Assessment Manual as the final compliance score for that particular criterion.

Extract from Patient Questionnaire

Patient Questionnaire to be used during the External Survey
FACILITY: _____
(1st Edition Hospital standards) Survey
Dates:_____

The attached questionnaire should be administered by external surveyors on a random sample of patients to establish the level of compliance with the respective criteria. The clinical condition/diagnosis of the patient interviewed will determine the manner in which the questions are asked in order to obtain appropriate responses. In deciding which patients to interview, surveyors should be guided by either the Unit Managers or the diagnoses. The person in charge of the ward should assist the surveyors to obtain the patients' permission prior to administering the questionnaire.

It is recommended that approximately five patients from each of the major disciplines are interviewed, The survey team decides on the procedure to follow: either one surveyor is tasked to do the full questionnaire or each surveyor interviews the required number of patients in the clinical department that he/she is responsible for.

Std. 4.2.2 During the entry and care processes, patients and their families (as appropriate) receive sufficient information about the following to make informed decisions:							
Crit. No.	**Criterion**	**Pts**	**NA**	**NC**	**PC**	**C**	**AV**
4.2.2.6 38.6.1.5	on alternative sources of care and services when the organisation cannot provide the care and services required, and the doctor assists the patient in seeking alternate care if requested	1					
		2					
		3					
		4					
		5					
Average score							
4.2.2.2 and 3 5.2.1.4, 5.5.1.5 10.3.5.1 10.3.5.3 to 8 38.4.1.1 and 2	their condition, proposed treatment, potential benefits and drawbacks, possible alternatives to the proposed treatment, likelihood of successful treatment, possible problems related to recovery, possible results of non-treatment	1					
		2					
		3					
		4					
		5					
Average score							

G: Additional Comments

1. Several criteria require compliance with laws and regulations. The guideline statements for these criteria indicate that " national" requirements need to be considered for assessing compliance. In instances where country laws/regulations do not exist for such an item, it will be expected that the facility will develop their own internal policy on such topic 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. Take note of the exception in standard 2.4 where the requirements also apply to all health care professionals who are allowed to render patient care, regardless of their employment status.

SE 25 STERILISING AND DISINFECTING UNIT

OVERVIEW OF THE STERILISING AND DISINFECTING UNIT

This chapter is designed to enable the staff in the particular service to assess, monitor and improve the quality of care in their own service.

The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and ensures that the unit complies with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement. This chapter therefore strengthens the standards in previous chapters, but cannot be used in isolation.

Standards

25.1 Management

25.1.1 *The sterilising and disinfecting unit (SDU) is managed to ensure the provision of a safe and effective service.*

Standard Intent

Departmental and service managers are primarily responsible for ensuring, that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each role in the department are defined in writing. Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Often the person in charge of the operating theatre assumes responsibility for the SDU/CSSD as well. Where the unit is physically separated from the theatre suite this may not be possible and another person assumes this function.

The person in charge of the unit should preferably be a professional nurse, 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 in a department, to ensure that staff receive guidance in the functions carried out. Departmental policies may be standardised for similar departments, or unique to the particular department. They need to be indexed, available, signed, dated, and have the authority of the organisational leaders. A system needs to be in place to ensure that departmental policies and procedures are known and implemented. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant services.

Of particular concern is that the policies or procedures should identify:

- how planning will occur
- the documentation required for the care team to work effectively
- special considerations
- monitoring requirements and
- special qualifications or skills of staff.

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) recording of issues of stock and maintaining stock levels.
f) ensuring that supplies are kept sterile.
g) acting on incidents where the sterility of supplies has not been maintained.
h) provision of emergency and after hours sterile supply/sterilisation

services.

i) safe use of SDU equipment, including autoclaves.
j) sterilisation of liquids
k) use of ethylene oxide

25.1.1 Criteria

25.1.1.1 A designated individual is responsible for the sterilising and disinfecting service.

This refers to a person appointed to the management position in terms of qualification and job specifications.

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

Where there is no job specification, this will be scored NC.

Depending on the size of the unit and whether it is attached to the operating suite or not, the person in charge may or may not be a professional nurse, with an operating theatre qualification.

Often the person in charge of the operating theatre assumes responsibility for the SDU/CSSD as well. Where the unit is physically separated from the theatre suite this may not be possible and another person assumes this function.

The person in charge of the unit should always be a registered nurse, 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.

Linked criteria:
1.3.1.1
2.2.1.1, 2.5.1.1

25.1.1.2 The manager ensures that policies and procedures, which include at least items a) to k) in the intent above, are available to guide the staff in the service and that they are implemented.

Linked criterion:
1.2.6.1

25.1.1.3 The manager plans and implements an effective organisational structure, to support his/her responsibilities and authority.

This criterion requires the availability of an organisation chart, which reflects the persons required to provide an adequate service for the facility. However where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships of formal lines of communication within the service.

Linked criterion:
1.1.1.2

25.1.1.4 The responsibilities of the unit manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager must be available.

Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

25.2 Facilities and Equipment

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

Standard Intent

Departmental managers need to work closely with organisational managers, to ensure that facilities and equipment are adequate. Departmental managers keep organisational managers informed of facilities, which are inadequate, additional equipment requirements, and the current state of facilities and equipment.

Even in a small one-room unit, the separation of activity sites and the flow of work can be achieved by careful planning. There should be a dedicated area for the cleaning of equipment and instruments.

25.2.1. Criteria

25.2.1.1 The design of the sterilising and disinfecting unit and the layout of equipment ensure flow of work from the soiled to the clean side of the unit.

Root criterion

The requirements will vary according to the size of the facility and the services provided.

Even in a small one-room unit, the separation of activity sites and the flow of work can be achieved by careful planning.

Linked criterion:
1.2.2.3

25.2.1.2 There is a washing and decontamination area, with clean running water and a sink connected to the sewage system.

There should be a dedicated area for the cleaning of equipment and instruments. Where gross decontamination takes place in a sluice room, it must be ensured that this is cleaned properly after use. Further cleaning should take place in a dedicated area.

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

There should be a dedicated area for the cleaning of equipment and instruments. Where gross decontamination takes place in a sluice room, it must be ensured that this is cleaned properly after use. Further cleaning should take place in a dedicated area.

The sterile supplies indicated here are both those pre-packed by the supplier and those sterilised on site.

It must be ensured that these items are stored in a manner which allows them to remain dry and intact i.e. maintain sterility.

25.2.1.4 There is a storage area for sterile packs with racks, which allow for an adequate circulation of air.

While slatted shelves are ideal, not all units will have this facility. It must then be ensured that there is a system of ensuring that autoclaved packs are completely cooled and dry before they are stored on solid shelves.

If there are shelves that are not slatted and, if there is no system to ensure that packs are cool and dry before being shelved, this criterion will be marked PC.

25.2.1.5 Adequate light and ventilation are available.

Linked criterion:
29.2.1.4

25.2.2 *Sterilising equipment is suited to its use.*

Standard Intent

There are many methods of sterilising equipment. Whatever methods are used, staff needs to ensure that the equipment used is effective. Systems must, therefore, be in place which ensures that sterility is obtained through the sterilisation processes.

The number of autoclaves required will depend upon the size of the hospital and the services provided. It will also depend upon how much is processed on site and how much is acquired pre-packed and sterilised. Also, whether the needs of both the operating theatre suite and other departments/services are catered for.

25.2.2 Criteria

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

The number of autoclaves required will depend upon the size of the hospital and the services provided. It will also depend upon how much is processed on site and how much is acquired pre-packed and sterilised. Also, whether there is provision to meet the needs of the operating theatre, emergency unit, labour unit and wards.

Linked criterion:
1.2.2.3

25.2.2.2 Autoclaves are appropriate to their use and the manufacturer's instructions are complied with.

Evidence must be provided of regular testing and maintenance according to recommended guidelines. Where legislation (e.g. testing of pressure vessels) is relevant, the requirements must be met.

There must also be evidence that staff have been trained in the correct use of the autoclaves

25.2.2.3 Sterilizing equipment is included in the organisation's equipment replacement and maintenance programme.

25.2.2.4 Where liquids are sterilised, an autoclave with a fluid cycle and a reverse osmosis or distillation plant are also provided.

This is seldom relevant. Most facilities make use of pre-packed bottles of sterilised water.

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

Critical criterion

An installation/commissioning certificate and evidence of compliance with the manufacturer's guidelines.

Evidence of maintenance and inspection certification must be provided.

There is evidence that staff have been trained in safety precautions.

Pregnant staff is prohibited from working with the sterilizer.
According to the type of installation and the manufacturers' recommendations, there is a method of measuring exposure e.g. environmental monitoring, dosimeters or similar method.

Linked criterion:
29.1.1.5

25.2.2.6 Autoclave sterilising ability is tested daily and the results thereof are recorded.

Critical criterion

Depending on the types of packs that are sterilised, different tests may be applied:

- *Physical/mechanical recorders e.g. graphs attached to autoclaves, record the time/temperature profile during a cycle.*
- *Chemical indicators such as special packaging and indicator tapes.*
- *Biological indicators (spore tests).*

Linked criterion:
25.4.1.1

25.2.2.7 The sterility of each pack is shown on indicator tapes, which are suited to the processes used.

Establish that the appropriate colour changes have taken place on the indicator tape. Also check that only the necessary amount of tape is used to avoid wastage, with its related costs. This will not affect the score but can be linked to the appropriate use of resources.

25.2.3 *The sterility of equipment and supplies is maintained.*

Standard Intent

Once sterility has been obtained, it is possible that this sterility may be lost in the storage, issue or distribution of sterile supplies. Systems need to be in place to ensure that packages reach the user sterile and intact.

25.2.3 Criteria

25.2.3.1 There is a mechanism to ensure that sterile supplies in stock are dated and used on a first in, first out basis.

25.2.3.2 The maintenance of sterility is checked before any sterile packs are distributed.

25.2.3.3 There is a system for the ordering, storage, maintenance and distribution of sterile supplies.

25.3 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of the management of the organisation to ensure, that standards are set throughout the organisation. 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 organisation's central/management/coordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include

a) availability of required items for the departments/services
b) loss of instruments
c) loss of sterility of packs
d) handling complaints related to the service

Once-off projects, for example, the purchasing of a new autoclave, do not qualify as a continuous quality improvement process and will be scored PC.

25.3.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

participation in monitoring near misses, sentinel and adverse events.

Linked criterion:
8.2.2.1

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

Critical criterion

Measurable indicators should reflect processes related to the service e.g.:
1. Number or % of packs where sterility was lost;
2. Number or % of loss of instruments;
3. Number or % of complaints relating to the service.

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

25.4 Prevention and Control of Infection

25.4.1 *The department/service implements infection prevention and control processes.*

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

25.4.1 Criteria

25.4.1.1 The department identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce risk.

The department participates in and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.

Linked criteria:
9.2.1.1 and 2
25.2.2.5

25.4.1.2 Infection control processes include prevention of infection from contaminated instruments.

25.4.1.3 Infection control processes includes the provision and correct usage of disinfectants/bactericidal agents.

25.4.1.4 Infection control processes include prevention of infection by the provision and correct use of personal protective equipment.

25.5 Risk Management

25.5.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

25.5.1 Criteria

25.5.1.1 The department conducts on-going monitoring of risks through documented assessments as part of the organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient and staff related risks, financial, legal risks, physical facility, security and environmental risks, etc should be included.

Linked criterion:
7.1.1.1

25.5.1.2 A system for the monitoring of negative incidents/near misses/sentinel events is available and includes the documentation of interventions and responses to recorded incidents.

Participation at department level, in the facility's overall system of the monitoring of negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.
Linked criteria:
7.1.1.7, 7.2.6.4

25.5.1.3 Security measures are in place and implemented for the safeguarding and protection of staff.

The department's participation in the facility's overall security plan will be evaluated.

Linked criterion:
7.4.1.4

25.5.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

25.5.1.5 Organisation policy on handling, storage, transporting and disposal of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 26: FOOD SERVICE

OVERVIEW OF FOOD SERVICE

This chapter is designed to enable the personnel in the particular service to assess, monitor and improve quality in their own service.

The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and to ensure that the food service complies with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement. This chapter, therefore, strengthens the standards in previous chapters but cannot be used in isolation.

Standards

26.1 Management of the Service

26.1.1 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 organisation is met, through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each staff member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement. Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

26.1.1 Criteria

26.1.1.1 A designated individual is responsible for the food service.

This requires an individual in the organisation who has the officially assigned duties of overseeing and taking responsibility for the management aspects of the food service. In some instances, these duties may be shared between the facility manager and a private, outsourced company.Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

In assessing the qualifications of the individual, one should always be guided by the organisation-specific post requirements. There are also very definite documented delegations to the respective post levels in the public sector against which one can measure compliance. Although of a more flexible nature in the private sector, one will generally find a job description/work profile against which to measure the requirement.
Where there is no job specification, this will be scored NC.

Linked criteria:
1.2.7.2, 1.3.1.1
2.2.1.1, 2.5.1.1

26.1.1.2 The food service manager ensures that policies and procedures are available to guide the staff and that they are implemented.

Linked criterion:
1.2.6.1
26.3.1.1

26.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisational chart which reflects the persons required to provide an adequate service for the facility. The organisational chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criterion:
1.1.1.2

26.1.1.4 The responsibilities of the unit manager are defined in writing.

A current job description/performance management agreement signed by the incumbent and the supervisor/manager, must be available.

Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

26.2 Facilities and Equipment

26.2.1 The department is designed to allow for hygienic food management.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements, and the current state of facilities and equipment.

National requirements will apply.

26.2.1 Criteria

26.2.1.1 The food service area meets with health and safety regulations.

Root Criterion

National regulations/requirements regarding the general hygiene of food premises will apply.

Linked criteria:
1.2.1.4, 1.2.2.3
26.2.1.6

26.2.1.2 There are separate hand-washing facilities in the food preparation area, with soap and safe means of hand drying e.g. paper towel, mechanical hand dryer.

Critical criterion

Evaluate the availability of appropriate, easily accessible and sufficient hand washing facilities with hot and cold water as well as adequate supplies of soap and paper towels in the food preparation area.

Linked criterion:
26.8.1.1

26.2.1.3 The temperature, ventilation and humidity levels are controlled and monitored to ensure satisfactory working conditions and cleanliness.

Evaluate the natural/artificial ventilation of the kitchen, e.g. windows, fans, air conditioners and the availability of a system for monitoring the daily kitchen temperature.

Linked criterion:
29.2.1.5

26.2.1.4 There is an effective method of fly control.

These methods could include fly screens, fly traps, ultra-violet insect control, etc.

26.2.1.5 There is adequate lighting and ventilation including in the storage areas.

26.2.1.6 Fridges and freezers can be opened from the inside using a safety release mechanism.

Critical criterion

The effectiveness of the safety escape mechanisms of all walk-in fridges and freezers should be tested, i.e. from the inside with the outside locking mechanism applied.

Linked criterion:
26.9.1.1

26.2.2 The department is designed to provide facilities for food handlers

26.2.2 Criteria

26.2.2.1 There are lockers for food handlers, for their outer clothing.

The requirement will vary according to the size of the facility and the number of staff. However, this area should be large enough for the staff complement and must be neat, tidy and secure.

Linked criterion:
1.2.2.3

26.2.2.2 There are adequate, suitable and conveniently placed change rooms, toilets and ablution facilities for food handlers.

Root criterion for 26.2.2.3 and 4

This refers to the availability, convenience, number in relation to staff complement and cleanliness of, and easy access to these areas.

Linked criterion:
1.2.2.3

26.2.2.3 Ablution and change facilities are well-lit and well-ventilated.

26.2.2.4 Ablution facilities are kept clean.

26.2.2.5 Adequate numbers of suitable refuse containers are provided in or near each change room, hand-washing facility and toilet area.

This refers to the availability of, and easy access to, refuse containers in the above-mentioned areas, the correct use of these containers and whether they are cleaned regularly to prevent overflow.

Linked criterion:
26.9.1.5

26.3 Policies and Procedures

26.3.1 Policies and procedures guide the management of the service.

Standard Intent

As indicated in 26.1.1 departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required
- special considerations
- monitoring requirements and
- special qualifications or staff skills.

Policies and procedures should address at least:

a) wearing jewellery on wrists and hands
b) wearing nail polish 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 and
h) provision of protective clothing for non-kitchen staff and visitors.

26.3.1. Criteria

26.3.1.1 The departmental manager ensures the availability and implementation of policies and procedures, which address at least items a) to g) in the intent above.

Root criterion

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the food service with other services in the formulation of policies should be sought, e.g. ordering special meals.

Linked criterion:
26.1.1.2

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

26.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all staff members.

26.3.1.4 Each policy and procedure is reviewed.

26.4 Menu Planning

26.4.1 Menus are planned and meals are prepared to meet client needs.

Standard Intent

Menus may be planned by an outsourced organisation, a dietician employed by the organisation, or other individuals with acceptable food management qualifications and suitable experience.

26.4.1 Criteria

26.4.1.1 A suitably qualified person advises on meal development.

Root criterion

This refers to the involvement of a dietician or other experienced person on meal planning and special diets.

Linked criterion:
10.7.1.1 and relevant criteria in all clinical services.
34.4.2.1

26.4.1.2 There is a planned circle menu suitable for different seasons.

The menu should make provision for criteria 26.4.1.4.to 6.
Menu implementation should be guided by recipes and portion control protocols.

26.4.1.3 Patients are provided with at least three meals per day.

Linked criteria;
1.3.1.5
10.7.1.1 and relevant criteria in all clinical services.

26.4.1.4 Wherever possible, patient food preferences are respected and substitutions made available.

26.4.1.5 Cultural preferences are taken into account.

Linked criterion:
26.7.1.2

26.4.1.6 The nutritional needs of patients without teeth and geriatric patients are considered.

26.4.1.7 Processes are in place to ensure that meals are served to patients at the correct temperature.

Guidelines should be available on the serving of hot or cold meals. Methods of keeping meals warm or warming them after plating (e.g. plug in food transport trolleys or microwave ovens in wards) must be available and implemented.

26.4.1.8 There are no more than 14 hours between the evening meal and the next substantial meal.

In cases where there are more than 14 hours between these meals and interim snacks are provided, this criterion will be scored PC. Evidence will be obtained from patient and staff interviews.

Evidence will be obtained from staff and patient interviews.

26.5 Maintenance of Food Hygiene

26.5.1 Food handlers maintain a hygienic food preparation environment.

Standard Intent

Foods are stored and prepared in accordance with written protocols, which have been devised 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, are kept separately. This

includes such foods as meat, poultry and fish.

This also applies to the following standard and criteria.

26.5.1 Criteria

26.5.1.1 There is a mechanism for ensuring that food handlers report the matter when they or members of their families have diarrhoea or vomiting, throat infections, skin rashes, boils or other skin lesions, or eye or ear infections.

Linked criterion:
26.9.1.1.

26.5.1.2 Food handlers wear appropriate protective clothing.

This may consist of hair covering, apron, overall, gloves and appropriate shoes.

Linked criterion:
9.2.2.2

26.5.1.3 There is a mechanism to prevent unauthorised individuals from entering food preparation areas.

This mechanism may consist of, for example, "No Entry" notices, demarcations, electronic access controls, etc.

26.5.1.4 Persons not normally employed in the food service wear protective clothing while in the area.

Linked criterion:
9.2.2.2

26.5.1.5 Preparation surfaces are cleaned and dried between uses for different activities.

26.5.1.6 Separate impervious cutting boards are kept for raw and cooked food.

26.5.1.7 Floors, walls and ceilings are clean.

26.5.2 Food products and meals are hygienically stored, prepared and served.

26.5.2 Criteria

26.5.2.1 Potentially high risk foods, unprepared food and prepared items are kept separately.

Incorrect storage of food can cause spoilage and food poisoning. High risk food includes meat, fish, chicken, eggs, dairy products, cooked rice, pasta and prepared salad.

Linked criteria:

9.2.1.5
26.5.3.3

26.5.2.2 Food is kept for the shortest time possible after cooking and before serving.

26.5.2.3 Food waste is put in covered containers and removed without delay from places where food is prepared.

Linked criterion:
26.9.1.5

26.5.2.4 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 chillier.

If the facility uses conventional cooking methods only, criteria 26.5.2.4 to 6 will be scored NA.

The Cook-Chill process involves the pre-cooking and freezing of meals (often off-site) and the re-heating of the meals, using specialised equipment, before serving.

26.5.2.5 Where the Cook-Chill Process of food preparation is used, the temperature of the heated food reaches at least 70 degrees centigrade, for not less than 2 minutes.

26.5.2.6 Food is served within 15 minutes of reheating.

26.5.3 Food is stored under conditions, which ensure security, hygiene and freshness.

Standard Intent

The food service manager has a system for ensuring that foods are stored under conditions that ensure security, hygiene and freshness. This requires the documentation of standards and monitoring the conditions under which foods are stored.

26.5.3 Criteria

26.5.3.1 The manager of the food service ensures that secure storage areas are available.

Assess the appropriateness of the physical facilities and adherence to policy on adequate maintaining of storage areas with regard to security, hygiene, ventilation, temperature, etc.

26.5.3.2 The management ensures that the foods are checked for quality, quantity and temperature on delivery.

26.5.3.3 The management ensures that the storage of food in dry storage, refrigerators and freezers complies with food hygiene regulations.

Root criterion for all the following criteria.

Linked criteria:
1.2.1.4
26.5.2.1

26.5.3.4 Foods are stored at acceptable temperatures; thermometers are used and temperature records are maintained.

26.5.3.5 Foods are stored separately from non-foods.

26.5.3.6 Foods are stored off the ground, on racks or shelving of an impenetrable material.

26.5.3.7 Different types of food are kept separately.

26.5.3.8 Stock is rotated according to the first expiry first out principle.

26.5.3.9 The food stores have ventilation and adequate lighting.

26.6 Quality Improvement

26.6.1 A formalised proactive quality improvement approach is maintained in the food service.

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/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:

a) patient satisfaction
b) complaints about meals
c) stock control
d) monitoring hygiene measures.

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.

26.6.1 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.

Linked criterion:
8.2.2.1

26.6.1.3 Indicators of performance are identified to evaluate the quality of meals provided.

Measurable indicators must reflect processes related to the food service. They should therefore, focus on high-risk, high-volume or problem-prone conditions and measure both the processes and the outcomes of the food service, e.g.

- *the number or percentage of complaints from patients regarding food over time*
- *the number or percentage of times the ward/s experienced the delivery of incorrect diets*
- *the number or percentage of incorrect deliveries from suppliers over time and*
- *the number or percentage of patients satisfied/dissatisfied with meals.*

Processes for quality improvement are selected in order of priority for evaluation and improvement in the quality of services provided.

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

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 organisational policies on patient and family rights. (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

26.7.1 Criteria

26.7.1.1 There are processes that support patient and family rights related to nutrition.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

Linked criterion:
5.1.1.3

26.7.1.3 The personnel respect the rights of patients and families and recognise cultural preferences related to meals.

Linked criteria:
5.1.1.3 and 6
26.4.1.5

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 organisational processes for infection prevention and control (Service Element 9).

26.8.1 Criteria

26.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root criterion

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1
26.2.1.2

26.8.1.2 Infection control processes include prevention of the spread of food related infections.

26.8.1.3 Infection control processes include effective hand washing procedures.

26.9 Risk Management

26.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

26.9.1 Criteria

26.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient and staff-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criteria:
7.1.1.1
26.2.1.6, 26.5.1.1

26.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated in the department. Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7; 7.2.6.4

26.9.1.3 Security measures are in place and implemented to ensure staff safety.

Linked criterion:
7.4.1.4

26.9.1.4 Fire safety measures, which include a fire blanket and fire extinguishers are implemented.

Appropriate fire safety equipment could include fire blanket, fire extinguishers, fire alarms, smoke detectors etc.
Linked criterion:
7.5.1.1

26.9.1.5 The organisation's policy on handling, segregation, storing and disposing of waste is implemented.

Linked criteria:
7.7.1.1
26.2.2.5
26.5.2.3

SE 27: LINEN MANAGEMENT

OVERVIEW OF LINEN MANAGEMENT

This chapter 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 laundry service may be provided on site or off site. Whatever system is used, the processes will be assessed in terms of the provision and distribution of linen, stock control, the collection of soiled and infected linen, laundering processes and the re-distribution of linen.

The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, 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 chapter therefore strengthens the standards in previous chapters, but cannot be used in isolation.

Standards

27.1 Management

27.1.1 The laundry service is managed to ensure the provision of a safe and effective service.

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each staff member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement. Documents prepared by each department define its goals and identify both current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they need to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

27.1.1. Criteria

27.1.1.1 A designated individual is responsible for the linen management service.

This requires an individual in the organisation who has the officially assigned duties of overseeing and taking responsibility for the management aspects of the laundry service. In some instances, these duties may be shared between the facility manager and outsourced company.

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

In assessing the qualifications of the individual, one should always be guided by the organisation-specific post requirements. There are also very definite documented delegations to the respective post levels in the public sector against which one can measure compliance. Although of a more flexible nature in the private sector, one will generally find a job description/work profile against which to measure the requirement.

Where there is no job specification, this will be scored NC.

Linked criteria:
1.2.7.2, 1.3.1.1
2.2.1.1, 2.5.1.1

27.1.1.2 The manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

Linked criteria:
1.2.6.1
27.3.1.1

27.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisation chart, which reflects the persons required to provide an adequate service for the facility. However, where there are a number of vacant post this criteria can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships of formal lines of communication within the service.

Linked criterion:
1.1.1.2

27.1.1.4 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.
Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

27.2 Facilities and Equipment

27.2.1 Where there is a laundry on site, the department is designed to allow for safe and effective processing of laundry.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements, and the current state of facilities and equipment.

National requirements will apply. The laundry must comply with the National Building Regulations and Building Standards Act,), the Occupational Health and Safety Act. In addition, the laundry must comply with the following requirements not covered in the criteria below:

- the roof and ceiling should be designed to minimize dust-collecting surfaces
- the floor should be well graded (slope) to allow for surface drainage in the washing area, outlets to drains must be clean and covered
- there should be access to conveniently sited ablution facilities, which may be shared with personnel from other departments
- there should be access to a staff tearoom and locker facilities for all on-duty personnel; and

- there should be a separate, strategically placed supervisory office, a washing material's store which is dry, a cleaner's area or room and a clean linen store or area.

27.2.1. Criteria

27.2.1.1 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.

Root criterion for all criteria in this standard except numbers 4, 9 and 12.

The requirements will vary according to the size of the facility. Allocated space and equipment should be adequate to deal with the current work load.

Linked criterion:
1.2.2.3

27.2.1.2 The laundry provides a clear flow of laundry from the soiled to the clean side with no crossover of these lines.

Critical criterion

There should be clearly indicated demarcation lines/barriers to ensure adequate separation between "clean" and "dirty" areas.

Linked criterion:
27.6.1.1

27.2.1.3 Trolleys, bins, vehicles or other equipment used for the transport of linen bags are designed to avoid damage to linen and to be easily cleaned.

27.2.1.4 Clean overalls, aprons, gloves and footwear for on-site sorting of used linen are provided and correctly used.

Linked criterion:
9.2.2.2

27.2.1.5 Washing machines are fitted with water level gauges or dip gauges and the quantity of water is regularly checked.

When applicable, documented evidence of machine maintenance and water level monitoring is required.
Other aspects to be monitored:
- *all washing machines drain into a closed or covered drain/sump and it is cleaned routinely;*
- *all washing machines are routinely disinfected; and*
- *when machines are not operational, they are kept clean and dry.*

Linked criterion:
29.2.1.2

27.2.1.6 The size and number of washing machines are adequate to meet the number of loads per hour, considering peak loads.

There should be an assessment of the equipment needs in order to avoid delays, taking into account factors such as the number of beds, occupancy rate, the operating hours of the laundry and the number of available personnel. The same should be done to determine the needs for other equipment such as ironers/laundry presses, driers, etc.

Linked criterion:
1.2.2.3

27.2.1.7 Ironers/laundry presses are adequate to ensure the processing of laundry items without undue delays.

27.2.1.8 The machine cage volume is specified by the manufacturer.

Washing loads per machine should comply with the manufacturer's instructions and need to be monitored. Implementation is measured in the next criterion.

27.2.1.9 Loads are weighed and recorded.

Refer to the criterion above. Documented evidence should be available to show that this is done.

27.2.1.10 Washing machines are fitted with accurate thermometers.

27.2.1.11 Thermometers are tested and calibrated as determined by the manufacturers.

Documented evidence should be available to show that thermometers are tested every 6 weeks and calibrated every year, or as often as determined by the manufacturers.

Linked criterion:
29.2.1.2

27.2.1.12 Pest control mechanisms are identified and implemented.

27.2.2 *Where there is no on-site laundry, the linen-bank facilities allow for efficient handling of linen.*

27.2.2 Criteria

27.2.2.1 The arrangement between the organisation and the off-site laundry clearly states the responsibility for sorting, counting, collection and delivery of linen.

Linked criterion:
1.2.7.3

27.2.2.2 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.

Critical criterion

There should be clearly indicated demarcation lines/barriers to ensure adequate separation between "clean" and "dirty" areas.

Linked criterion:
27.6.1.1

27.2.2.3 Trolleys, bins, vehicles or other equipment used for the transport of linen bags are designed to avoid damage to linen and to be easily cleaned.

Linked criterion:
1.2.2.3

27.2.2.4 Clean overalls, aprons, gloves and footwear for on-site sorting of used linen are provided and correctly used.

Linked criterion:
9.2.2.2

27.2.2.5 Soiled linen sent to the off-site laundry is sorted into bags (or other acceptable containers), which clearly indicate the content.

27.2.3 Linen stock control mechanisms are implemented.

27.2.3 Criteria

27.2.3.1 Access to the laundry/linen-bank is controlled.

27.2.3.2 There is a method of accounting for the numbers of different linen items sent for laundering.

Whether laundry is processed on site or sent to an off-site laundry, a system of counting items that arrive from the various departments for laundering should be implemented.

27.2.3.3 There is a process to verify the numbers and physical condition of linen items sent and received.

Critical criterion

This is particularly important when the services of an off-site laundry are used.

Linked criterion:
1.2.2.2

27.2.3.4 A record is kept of linen issued.

27.2.3.5 Secure storage facilities are available.

27.2.3.6 There is an inventory of all linen stored.

This refers to linen in circulation, i.e. in the linen bank and the departments. It does not include new linen not yet issued from the provisioning store.

Linked criterion:
1.3.1.5

27.2.3.7 Records are audited.

27.2.3.8 All losses are investigated, reported and recorded.

Linked criteria:
3.3.1.5
27.7.1.2

27.3 Policies and Procedures

27.3.1 Policies and procedures guide the management of the service.

Standard Intent

As indicated in 27.1.1, departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant services.

It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required
- special considerations
- monitoring requirements and
- special qualifications or staff skills.

Policies and procedures should address, at least;

a) separating the personnel who work in the clean and the soiled areas
b) marking linen to identify ownership
c) washing patients' private clothing
d) the delivery of clean linen
e) how to obtain of clean linen in an emergency
f) handling infected linen
g) wearing protective clothing
h) searching used linen for sharps
i) sorting linen; and
j) handling of linen brought by patients.

27.3.1. Criteria

27.3.1.1 The departmental manager ensures that policies and procedures, which address at least items a) to j) in the intent above, are available to guide the department.

Root criterion

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the linen management service with other services in the formulation of policies should be sought, e.g. handling of infected linen.

Linked criteria:
27.1.1.2

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

27.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel.

27.3.1.4 Each policy and procedure is reviewed.

27.4 Quality Improvement

27.4.1 A formalised proactive quality improvement approach is maintained in the laundry service.

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of the management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/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 and
- the number of instruments found in operating theatre linen.

As part of the laundry quality improvement processes 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 monitor these indicators
- the monitoring of these indicators and corrective steps taken when standards/goals are not achieved and
- analysed (graphed and/or tabled) results, as appropriate.

A once-off project such as supplying a thermometer for a washing machine does not qualify as a continuous quality improvement process and will be scored NC.

27.4.1 Criteria

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

Processes for quality improvement are selected in order of priority for evaluation and improvement in the quality of services provided.

Linked criterion:
8.2.2.1

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

Measurable indicators must reflect processes related to the linen management service. They should, therefore, focus on high-risk, high-volume or problem-prone conditions and measure both the processes and the outcomes of the linen management services, as follows;

- *the number or percentage of complaints from the wards regarding stained linen over time*
- *the number or percentage of times the wards experienced linen stock-outs and*
- *the number or percentage of items of linen lost over time.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

27.5 Patient Rights

27.5.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during the observation of patient care processes and patient interviews.

27.5.1 Criteria

27.5.1.1 There are processes that support patient and family rights related to bed-linen provision for comfort.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

Linked criterion:
5.1.1.3

27.5.1.2 The personnel respect the rights of patients and families related to dignity by the provision of appropriate hospital attire.

27.6 Prevention and Control of Infection

27.6.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

27.6.1 Criteria

27.6.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root criterion

The department participates in and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.

Linked criteria:
9.2.1.1
27.2.1.2, 27.2.2.2

27.6.1.2 Infection control processes include prevention of the spread of infection related to infected linen.

27.6.1.3 Infection control processes include prevention of the spread of infection related to the separation of soiled and clean linen.

27.6.1.4 Infection control processes include effective hand washing procedures.

27.7 Risk Management

27.7.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

27.7.1 Criteria

27.7.1.1 The department conducts on-going monitoring of risks through documented assessments as part of the organisational risk management programme.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient and staff-related risks, financial and legal risks, the physical facility, security and environmental risks, should be included.

Linked criterion:
7.1.1.1

27.7.1.2 A system for monitoring incidents/near misses/ sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated in the department.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7; 7.2.6.4
27.2.3.8

27.7.1.3 Security measures are in place and implemented to ensure staff safety.

The department's participation in the facility's overall security plan will be evaluated.

Linked criterion:
7.4.1.4

27.7.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

27.7.1.5 The organisation's policy on handling, segregation storing and disposing of waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion: 7.7.1.1

SE 28 HOUSEKEEPING SERVICE

OVERVIEW OF HOUSEKEEPING SERVICE

This chapter is designed to enable the personnel in the particular service to assess, monitor and improve quality in their own service.

The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and ensures that the housekeeping service complies with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement. This chapter therefore strengthens the standards in previous chapters but cannot be used in isolation.

Standards

28.1 Management of the Service

28.1.1 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 organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each staff member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement. Documents prepared by each department define its goals and identify both current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

28.1.1 Criteria

28.1.1.1 A designated individual is responsible for the housekeeping service.

This requires an individual in the organisation who has the officially assigned duties of overseeing and taking responsibility for the management aspects of the cleaning service. In some instances, these duties may be shared between the facility manager and a private, outsourced company. Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

In assessing the qualifications of the individual, one should always be guided by the organisation-specific post requirements. There are also very definite documented delegations to the respective post levels in the public sector against which one can measure compliance. Although of a more flexible nature in the private sector, one will generally find a job-description/work profile against which to measure the requirement.

Where there is no job specification, this will be scored NC.
Linked criteria:
1.2.7.2, 1.3.1.1.
2.2.1.1, 2.5.1.1

28.1.1.2 The housekeeping service manager ensures that policies and procedures are available to guide the staff and that they are implemented.

Linked criteria:
1.2.6.1
28.3.1.1

28.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisation chart, which reflects the persons required to provide an adequate service for the facility. However where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships of formal lines of communication within the service.

Linked criterion:
1.1.1.2

28.1.1.4 The responsibilities of the unit manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.
Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

28.2 Facilities and Equipment

28.2.1 Facilities and equipment are adequate to provide a safe and effective cleaning service.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements, and the current state of facilities and equipment.

28.2.1 Criteria

28.2.1.1 Secure storage areas and well-maintained equipment are available to the housekeeping personnel.

Root criterion for the first three criteria and criterion 28.2.1.7

The requirements will vary according to the size of the facility and space available. Allocated storage space should be adequate to deal with all housekeeping equipment. This area should be clean, tidy and securely locked. Documented evidence of maintenance and monitoring of equipment should be provided where applicable, e.g. buffers, polishers, mops, buckets. Equipment currently in use should be disinfected regularly and kept clean and dry when not in use.

Linked criterion:

1.2.2.3

28.2.1.2 Chemicals for cleaning are safely stored, out of the reach of patients, children and visitors.

Critical criterion

This refers to a dedicated chemical store or storage space for cleaning materials. This area should be well-ventilated, neat and tidy, all chemicals should be stored above floor level and the store should be locked at all times. Access needs to be controlled. Make sure that the necessary warning signs are displayed.

Linked criterion:
28.7.1.1

28.2.1.3 There is adequate storage place for brooms and mops.

This refers to all storage areas for mops and brooms in the facility and ensures that infection control measures are not compromised. Mops and brooms should be stored with their heads up. They should be clean and dry when not in use, and be routinely disinfected after use.

Mop heads must be washed after each use and disinfected daily.

There may be a system for taking mop heads to the laundry every day to be washed and exchanging them for clean ones. A special system for preparing the mop heads according to the manufacturer's instructions may also be used.

If mops and brooms are stored in the sluice room this criterion will be marked PC.

28.2.1.4 Mops and brooms are cleaned and dried before being stored.

Linked criterion:
28.6.1.1

28.2.1.5 Cleaning cupboards are adequately ventilated.

28.2.1.6 Soiled linen is placed in bags designated for that purpose.

This refers to the management of soiled and infected linen in wards, isolation areas and theatre in the manner required by the infection control policy, e.g. the use of colour-coded bags.

Linked criterion:
28.6.1.1

28.2.1.7 Soiled linen is stored in a secure facility.

This refers to the mechanisms whereby unauthorised access to store areas for soiled/infected linen is prohibited, e.g. "no entry" signs, etc. It is advisable to lock the storage facility in areas where children are accommodated.

28.3 Policies and Procedures

28.3.1 Policies and procedures guide the management of the department.

Standard Intent

As indicated in 28.1.1, departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

It is particularly important that the policies or procedures indicate:

- how planning will occur
- the documentation required
- special considerations
- monitoring requirements
- special qualifications or staff skills.

Policies and procedures should address, at least,

a) the supervision of cleaning personnel
b) the mixing/dilution and use of chemicals for cleaning
c) the safe storage of cleaning materials
d) hygienic storage of mops and brooms
e) appropriate cleaning methods and materials for various surfaces
f) handling of used and infected linen
g) cleaning at times that is least disturbing to the patient care services.

28.3.1 Criteria

28.3.1.1 The departmental manager ensures that policies and procedures, which address at least items a) to g) in the intent above, are available to guide the department.

Root criterion

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the housekeeping service with other services in the formulation of policies should be sought, e.g. times for collecting clinical waste.

Linked criterion:
28.1.1.2

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

28.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel.

28.3.1.4 Each policy and procedure is reviewed.

28.4 Waste Disposal

28.4.1 The housekeeping personnel work with the infection control committee to ensure safe waste disposal.

Standard Intent

Housekeepers play an important role in the removal of clinical 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.

28.4.1 Criteria

28.4.1.1 Waste is segregated in accordance with documented controls.

Root criterion

This applies to all areas in the facility where waste is generated.
Assess the use of protective clothing by the waste handler and housekeeping personnel is it being used correctly? Also assess the way waste is transported to the collection area.

Linked criterion:
7.7.1.1

28.4.1.2 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.

Critical criterion

This refers to the implementation of the organisation's policy in all areas where waste is generated.

Linked criteria:
1.3.1.5
7.7.1.2
28.7.1.5

28.4.1.3 Waste is protected from theft, vandalism or scavenging by animals.

This refers to all waste storage areas; take tidiness into account, as well as the security and protection of general healthcare and chemical waste (this includes pharmaceutical and radiological waste), plate waste, etc.

28.4.1.4 Waste is collected at appropriate times, so that hazards are not caused.

Collection times should be appropriate for all collection points to prevent waste from building up (this is a potential hazard).

Linked criterion:
1.2.7.3

28.5 Quality Improvement

28.5.1 A formalised proactive quality improvement approach is maintained in the housekeeping service.

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/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:

a) the use of cleaning chemicals
b) the cleanliness of cleaning equipment
c) infection control measures
d) waste management
e) the cleanliness of ablution facilities
f) 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.

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.

28.5.1 Criteria

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

Linked criterion:
8.2.2.1

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

Measurable indicators must reflect processes related to the housekeeping service. They should, therefore, focus on high-risk, high-volume or problem-prone conditions and measure both the processes and the outcomes of the housekeeping services, e.g.

- *the number of times the waste was not collected on time*
- *the default rate in respect of cleaning the bathrooms and completing the hygiene checklists*
- *the number or percentage of patient complaints or satisfaction regarding the cleanliness of the units/wards.*

Processes for quality improvement are selected in order of priority for evaluation and improvement in the quality of care provided

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

28.6 Patient Rights

28.6.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during the observation of patient care processes and patient interviews.

28.6.1 Criteria

28.6.1.1 There are processes that support patient and family rights related to a safe and clean environment.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

Linked criterion:
5.1.1.3

28.6.1.2 The personnel respect the rights of patients and families related to protection from exposure to infection.

28.7 Prevention and Control of Infection

28.7.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

28.7.1 Criteria

28.7.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes.

Linked criteria:
9.2.1.1,
28.2.1.4
28.2.1.6

28.7.1.2 Infection control processes include prevention of the spread of infection related to the cleaning and storage of cleaning equipment.

28.7.1.3 Infection control processes include prevention of the spread of infection related to the correct dilution of cleaning chemicals.

28.7.1.4 Infection control processes include prevention of the spread of infection related to implementing the colour-coded identification of mops for different areas

28.7.1.5 Infection control processes include effective hand washing procedures.

28.8 Risk Management

28.8.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

28.8.1 Criteria

28.8.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient and staff-related risks, financial and legal risks, the physical facility, security and environmental risks, etc. should be included.

Linked criteria:
7.1.1.1
28.2.1.2

28.8.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated in the department.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7; 7.2.6.4

28.8.1.3 Security measures are in place and implemented to ensure safety of staff, patients and visitors.

Linked criterion:
7.4.1.4

28.8.1.4 Fire safety measures are implemented.

Linked criterion:
7.5.1.1

28.8.1.5 The organisation's policy on handling, storing and disposing of waste is implemented.

Linked criteria:
7.7.1.1
28.4.1.1 and 2

SE 29 MAINTENANCE SERVICE

OVERVIEW OF MAINTENANCE SERVICE

The Maintenance service may also be known in some organisations as the Hospital Engineering or Facility Management department. Whatever it is known as, it concerns itself with the management and maintenance of hospital plant, machinery and buildings, and non-medical equipment.

Laws, regulations and inspections by national governmental and local authorities determine in large part, how a facility is designed, used and maintained. All organisations, regardless of their size and resources, must comply with these requirements, as part of their responsibilities to their patients, families, personnel and visitors. Organisations begin by complying with laws and regulations. Over time, they become more knowledgeable about the details of the physical facility they occupy. They begin to proactively gather data and carry out strategies to reduce risks and enhance the patient care environment.

Buildings, grounds, plant and machinery are provided and maintained, and do not pose hazards to the occupants. Utility systems (electrical, water, oxygen, ventilation, vacuum and other utility systems) are maintained, to minimise the risks of operating failures.

Ensuring that buildings, grounds, plant and machinery are provided and maintained requires that personnel be knowledgeable and competent.

Standards

29.1 Management of the Service

29.1.1 The maintenance service is managed, to ensure the provision of a safe and effective service.

Standard Intent

An individual, who is suitably qualified, and with proven competence, is appointed to manage the service. The accountabilities and responsibilities of this individual are clearly defined.

The manager possesses documentation, outlining relevant laws, regulations and other requirements, applicable to the organisation's facilities.

The national legislation referred to in criterion 29.1.1.5 is that which relates to safety of the buildings, plant , machinery, electrical installations, water supplies and any other components of the physical facility that require specific legally mandated attention, such as mandatory safety inspections etc.

29.1.1 Criteria

29.1.1.1 A designated individual is assigned responsibility for management of the service.

Compliance is measured against the job specifications.

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

Where there is no job specification, this will be scored NC.

Linked criteria:
1.3.1.1
2.2.1.1

29.1.1.2 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager must be available. Key performance areas must be clearly stated.

Linked criteria
1.3.1.2
2.3.1.1

29.1.1.3 The maintenance manager identifies the requirements of the organisation's maintenance programme, which informs the budgeting process.

Refer to standard 29.2.1

Linked criterion:
3.1.1.3

29.1.1.4 The manager works with the multidisciplinary team to develop and implement risk management systems according to organisation policy.

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide risk management systems.

Evidence is required in the form of documented safety related policies and procedures, provision of protective equipment and clothing, relevant safety notices, maintenance inspection checklists and records of safety related training for maintenance personnel. Proof is required that the manager is actively involved in the organisation's health and safety structures.

Linked criteria:
1.2.8.1
29.2.1.2
29.6.1.1

29.1.1.5 Policies and procedures to enable the organisation to comply with national legislation are implemented.

The national legislation is that which relates to safety of the buildings, plant , machinery, electrical installations, water supplies and any other components of the physical facility that require specific legally mandated attention, such as mandatory safety inspections etc.

Linked criteria:
1.2.1.4, 1.2.6.1
7.5.1.1
25.2.2.4

29.1.2 There are an adequate number of suitably qualified and/or experienced personnel to provide a safe and effective service.

Standard Intent

Management ensures that there are an adequate number of competent personnel available to manage routine and emergency functions, to meet the needs of a safe and effective health service. Personnel may be in the employ of the organisation or contracted out. Where contracted personnel are utilised, there need to be clear contracts, which outline their responsibilities. Personnel need to have their roles clearly defined, and management needs to ensure, that they maintain competence.

29.1.2 Criteria

29.1.2.1 There are sufficient, suitably trained and/or experienced personnel to manage the organisation's buildings, plant and machinery.

Compliance is measured against the relevant post allocations on the official personnel establishment, as well as national legislated requirements in terms of professional registration or competency.

Linked criterion
2.2.1.1

29.1.2.2 Where there are no in-house personnel to perform these functions, the services of consultants/service providers are utilised.

Documented evidence is required that clearly specifies the functions/responsibilities of each consultant/service provider, together with details of any administration-specific requirements relating to call out procedures such as obtaining authority, issuing of order numbers etc. , especially in emergency after hours situations.

Linked criteria:
1.2.7.3

29.1.2.3 Names of specialist service contractors for buildings, plant and machinery are available, with their locations, telephone numbers and the responsible persons specified.

29.1.2.4 There is a system for the provision of emergency technical backup, twenty four (24) hours a day, seven (7) days a week.

Critical criterion

Documented call-out procedures, together with a current standby duty roster, needs to be available.

Linked criteria
1.2.7.3
2.2.1.5
31.2.1.8

29.2 Facility Management

29.2.1 The organisation provides planned maintenance and replacement processes, to ensure the safety of facilities, plant and machinery.

Standard Intent

The first consideration for any physical facility is the laws, regulations and other requirements related to that facility. Such requirements may differ, depending on the age of the facility, the location of the facility and other factors. The organisation's leaders, including governance and senior management, are responsible for knowing what national and local laws, regulations and other requirements are applicable to the organisation's facilities, and for implementing the applicable requirements.

Prevention and planning are essential to creating a safe and supportive patient care facility. The organisation's leaders, including governance and senior management,

are 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 facility.

The maintenance manager ensures that organisational policies and procedures are implemented. These policies comply with current legislation.

Monitoring essential systems helps the organisation to prevent problems, and provides the information necessary to make decisions on system improvements, and to plan for the upgrading or replacement of utility systems.

29.2.1 Criteria

29.2.1.1 The facility has a documented preventative maintenance management programme or systems in place.

Root criterion

A maintenance management programme refers to a system which will include:

1. *A schedule indicating when the prescribed Inspection and Preventative Maintenance (IPM) procedures are due on each item.*
2. *Operators and service manuals should be available for all equipment and machinery.*
3. *Manufacturers' recommendations inform the IPM criteria.*
4. *A record of when procedures or repairs were carried out and by whom.*
5. *A description of what was done and a list of parts replaced or fitted.*
6. *The results of qualitative and/or quantitative tests performed.*
7. *The various tasks, procedures and measurements/observations that need to be performed for each IPM.*
8. *A means of "flagging" recurring or critical problems for risk management purposes.*

Maintenance management programmes/systems may be computerised or manual, provided they meet the requirements described in this guideline.

Linked criteria:
1.2.2.3
10.2.1.1 and similar criteria in all clinical services
29.6.1.1

29.2.1.2 The department holds regular, documented, current, and accurate inspections of its physical facility, plant and machinery.

Critical criterion

Linked criteria:
10.2.1.6 and similar criteria in in-patient services i.e. SEs 11 to 16 and 40
22.2.2.8
24.2.2.7
27.2.1.5, 27.2.1.11
29.6.1.1

29.2.1.3 The inspection identifies remedial action required to address situations that could have an impact on health and safety issues.

This includes the inspections as referred to in 29.2.1.1-2

Documented processes need to be in place whereby any deficiencies picked up during the inspection are remedied and the results of the remedial action monitored and documented as part of the risk management and quality improvement processes.

29.2.1.4 Air-conditioning is installed in theatres and sterilising departments and is tested and maintained.

Air-conditioning needs to be installed and maintained in accordance with relevant national standards. Documented evidence is required of:

1) the commissioning of the installation ,certifying compliance with the applicable standards; and
2) regular inspections, testing and maintenance of filters as determined by the policies and procedures. (Particle counts assess the efficacy of HEPA (high - efficiency particulate air) filters by measuring the concentration of fine particulate matter in the air in theatres and other sterile areas. This is usually done bi-annually).

Linked criteria:
17.2.1.7
25.2.1.5

29.2.1.5 Temperature and ventilation control mechanisms are installed and maintained in the pharmacies, kitchens, laundries and other relevant areas.

Ventilation in these departments needs to be monitored to ensure adequate air-change and temperature control. This monitoring needs to be included in the institution's IPM. Take note of any national legislation that may apply to these areas.

Linked criteria
9.2.1.7
21.5.1.9
26.2.1.3

29.2.1.6 Emergency generators are tested on full load according to manufacturers' specifications.

Critical criterion

Testing under load (i.e. switching off the normal power grid supply) is essential, as failure to do this merely tests the diesel engine and not the generator and associated switchgear and distribution boards.

A policy on the testing of the emergency power system needs to be in place together with the procedures to be followed. These should include:
- ascertaining whether it is safe to perform the test at the time envisaged (i.e. that there are no critical procedures under way in any patient care area – especially locations such as theatre, critical care units, casualty and maternity)

- giving adequate warning to all departments of the intended power failure simulation, especially to clinical areas such as theatre and ICU.
- testing the functionality of all emergency power sockets and lighting throughout the institution
- informing all departments once power has been restored.
All tests need to be fully documented and form part of the IPM

Linked criterion
29.6.1.1
30.1.1.6

29.2.1.7 There are site and floor plans that depict the locations and layout of the main services (viz. water, sanitation, electricity supply).

Linked criterion:
7.5.1.6

29.2.2 Medical gas systems are regularly inspected, maintained and, when appropriate, improved.

Standard Intent

The organisation plans its needs for oxygen supplies, according to the needs of the patients served.

Policies and procedures are available and followed relating to the storage, testing and safety of gas supplies.

Gas cylinders are 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”.

Portable gas supplies are stored in appropriate brackets or specific holders, in designated areas only.

Emergency oxygen supplies ensure that the number of available outlet points meet patient needs. Where there is no piped oxygen and vacuum supply, there is at least one mobile oxygen supply and one suction machine per ward, and more depending on the number of beds/cots in the ward. All necessary fittings for oxygen and suction are suitable for all patients, including children, and are in good working condition.

29.2.2 Criteria

29.2.2.1 Medical gasses (oxygen, nitrous oxide and medical air) supplies are available according to the operational requirements of the institution.

Root criterion

In larger hospitals, oxygen is normally supplied by a Vacuum Insulated Evaporator (VIE), nitrous oxide by a bank of manifold connected cylinders, and medical air by oil free compressors via appropriate filters and driers. In all these cases backup is provided in the form of manifold connected cylinder banks, mostly fitted with automatic switchover valves and alarms that operate in the event of a failure in the primary supply.

Some hospitals may have Entonox in their maternity wards and possibly trauma units, while Carbogen and Carbon Dioxide may still be found in the theatres of older institutions.

Where there is no piped gas, the organisation should have an arrangement, which addresses the number of cylinders and related ancillary equipment such as pressure regulators, flow meter-regulators etc. required to adequately satisfy patient needs, with special attention being given to emergency situations that may arise.

Linked criteria:
1.3.1.5
10.2.1.2 and similar criteria in in-patient services.
22.2.2.4
23.2.2.3
24.2.2.3
29.6.1.1

29.2.2.2 Medical gas supply systems comply with safety standards.

Documented certification is required of such compliance with national requirements.

Examples of such requirements could include the following:
- Cylinders should be protected from extremes of weather and stored in a dry, well-ventilated area away from heat or ignition sources.
- Cylinders (full or empty) should be secured in the upright position either by chains or straps to prevent them falling. Smaller cylinders may be placed in specially made stands.
- Oxidising and flammable gasses must be stored in separate rooms that are constructed of materials with a minimum fire rating of 1 hour.
- The cylinder store must be equipped with acceptable fire extinguishing facilities, and signage at the entrance should include a sign indicating that it is a flammable gas store and symbolic signs for "no smoking", "no naked flames", "no oil" and "no entry".

Linked criterion:
7.5.1.1

29.2.2.3 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.

Refer to policy requirements in criterion 29.1.1.5, as well as inspection requirements in 29.2.1.1-3.

Take note that the inspection needs to include all outlet points i.e. in all departments where piped oxygen is delivered, as well as all low-level oxygen alarms wherever these are installed in the facility.

29.2.2.4 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 supplies and is regularly tested and documented.

Critical criterion

In some hospitals there is a bulk VIE for the main oxygen supply with banks of cylinders as backup. In others, there are only cylinder banks. Regardless of which system is in use, the primary objective of this criterion is to ensure that there is an alarm if the pressure within the pipeline drops below the normal operating level (± 410 kPa). It should be noted that there may also be separate alarm systems for the VIE and the gas-bank manifolds.

Documented evidence is required of regular testing of all gas alarm systems.

Linked criterion:
29.6.1.1
30.1.1.7

29.2.2.5 Medical gas alarm systems are regularly tested and documented.

These alarms could include warning systems (slave alarms/sub-alarms) in other areas of the hospital e.g. operating theatre or intensive care unit.

29.2.2.6 Backup supplies of medical gasses are available and strategically positioned to ensure timely deployment in emergencies.

Medical gas includes any type of gas that is used within the medical environment.

29.2.3 Medical vacuum systems are regularly inspected, maintained and, when appropriate, improved.

Standard Intent

The organisation plans its needs for vacuum supplies, according to the needs of the patients served.

Policies and procedures are available and followed relating to the testing and safety of pipeline vacuum systems and mobile/portable electric suction units.
Vacuum systems are regularly tested in accordance with national arrangements or manufacturer's instructions.

29.2.3 Criteria

29.2.3.1 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.

This criterion requires that the "exhaust" outlet pipe from the vacuum pump leads to the outside of the enclosure or room in which the vacuum pumps are housed. The system needs to be capable of providing sufficient suction to all points in the facility. Regular tests need to be performed to ensure this and to detect any degradation in the level of vacuum; e.g. due to fluids having been accidentally sucked into the line etc. (The tests can be performed using a standard suction regulator or vented gauge).

These tests need to be documented to provide evidence of such sufficiency.

29.2.3.2 Where there is piped vacuum, backup facilities are provided.

In hospitals with a piped vacuum system there are normally two (or more) electrically operated vacuum pumps – one in operation and the other as a standby in the event of the first pump failing. They should be alternated at a period determined by the organisation's policy in order to "spread the load".

These vacuum pumps are usually also connected to the emergency supply provided by the standby generator and there are usually also portable electrically operated suction units available.

However, in the event of the standby generator failing during a power grid failure, there need to be adequate alternative suction facilities (e.g. battery manually operated suction pumps) available to critical areas, e.g. theatres, ICUs, maternity, emergency unit, etc.

In organisations where UPS systems are available such alternative arrangements may not necessarily be required.

Linked criteria:
1.3.1.5
10.2.1.2 and all relevant criteria in clinical services.
29.6.1.1

29.3 Emergency Preparedness

29.3.1 The organisation has a process, which is tested on a regular basis, to protect facility occupants in the event of water or electrical system disruption, contamination or failure.

Standard Intent

The organisation needs to protect patients and personnel in emergencies, such as system failure, interruption or contamination.

To prepare for such emergencies, the organisation identifies the equipment, systems and locations that pose the highest risk to patients and personnel. For example it:

- Identifies, where there is a need for illumination, refrigeration, life-support,

and clean water for cleaning and sterilisation supplies
- assesses and minimises the risks of total utility system failures in these areas
- tests the availability and reliability of emergency sources of power and water; and
- documents the results of tests.

Water quality can change suddenly due to many causes, some of which can be outside the organisation, such as a break in the supply line to the organisation, or contamination of the city's water source. An uninterrupted source of clean water is essential to meet patient care needs, both routine and urgent, 24 hours a day. Regular and alternate sources such as boreholes can be used. In the event of the overhead reservoir tank being the only alternative source, note that if the problem is due to contamination of the town's supply, then it is likely that the contents of the tank will also be contaminated. It is thus necessary to have contingency plans in place for the provision of drinkable water via tanker from some other source.

Water quality is also a critical factor in clinical care processes, such as chronic renal dialysis. Thus, the organisation establishes a process to regularly monitor water quality, including the regular biological testing of water, used in chronic dialysis. The frequency of monitoring is based, in part, on previous experience with water quality problems. The monitoring can be carried out by individuals designated by the organisation, such as personnel from the clinical laboratory, or by public health or water control authorities outside the organisation.

An uninterrupted source of electricity is essential to meet patient care needs, both routine and urgent, 24 hours a day. Regular and alternate sources can be used.
Critical points to be lighted by emergency power are identified and listed. These include:
- operating theatres and recovery rooms
- delivery rooms' lights and sockets
- strategic lights and sockets in ward corridors
- critical care wards
- the neonatal nursery and
- casualty and trauma areas.

Emergency electricity supplies:
- each bed/cot/crib is serviced by at least two electricity socket outlets
- each patient care area is provided with a socket outlet, which is connected to the emergency power supply, provided that at least one emergency supply socket is available per 3 beds
- all emergency supply socket outlets are appropriately demarcated.

Records of all checks are available.
Monitoring data are collected and documented for the medical utility management programme and monitoring data are used for the purposes of planning and improvement.

29.3.1 Criteria

29.3.1.1 Electrical power is available 24 hours a day, seven days a week, from regular or emergency sources.

Critical criterion

The primary source of power is normally from a municipal or national supply grid. In the case of some rural institutions in very remote areas, the primary source may be a diesel-powered generator, photovoltaic cells ("solar panels") or even a small hydroelectric plant at a nearby river. Whatever the primary source, there must be an alternative source as backup supply as required in the next criterion.

Linked criteria:
1.2.2.3
10.2.1.7 and similar criteria in in-patient services.
22.2.1.3
23.2.1.3
24.2.1.3
29.6.1.1

29.3.1.2 The areas and services at greatest risk when power fails, have been identified and provision has been made for emergency electrical supply.

Those areas and services that are usually regarded as being at the greatest risk are listed in the statement of intent (for standard 29.3.1) under the heading "electricity supply".

The organisation needs to have in place documented contingency plans that are known to all relevant persons (e.g. departmental heads etc). This information could also be included in the organisation's disaster management plans.

29.3.1.3 The organisation ensures that relevant personnel are trained to use/operate electrical supply systems to access power in emergencies.

In most instances, the standby generator will start automatically in the event of a power failure. However, some older units need to be manually started. Usually, all operations pertaining to the correct functioning of the standby generator are handled by the organisation's technical personnel (maintenance department). In smaller institutions however, where technical backup may be limited, suitable persons need to be identified and trained in the procedures to be followed. Such training needs to be held at regular intervals and must be fully documented.

29.3.1.4 Servicing and testing of the uninterruptible power supplies (UPS) and/or battery backup systems is documented.

Critical criterion

*The equipment related standards for both theatre and critical care areas require that where life-support and/or critical monitoring equipment that does **not** have internal backup battery supplies is utilised, an uninterruptible power supply system (UPS) is installed. Documented evidence of maintenance/testing is required.*

It is important to note the special circumstances with regards to the theatre lamp/s. An auto-start standby generator can take anything from 10 to 20 seconds to come on line, while a manual start unit would take infinitely longer, for obvious reasons. Even ten

seconds of darkness during an operation could seriously compromise both patient and personnel safety, and the same goes for life-support and critical monitoring equipment - hence the requirement for a UPS and/or battery backup for both this type of device and operating lamps/lights.

Linked criteria:
6.2.2.3
13.2.2.4
17.2.1.8-9
29.6.1.1
30.1.1.6

29.3.1.5 Regular and/or emergency water supplies, including drinkable water, are available 24 hours a day, seven days a week.

Critical criterion

The continuous availability of drinkable water is vital. In most instances, the institution obtains its primary supply from the local municipality or other such source. In outlying districts, however, the primary source may be a river or borehole. Whatever the source, there needs to be an alternative supply in case the primary supply is, for whatever reason, rendered unusable. (refer to the requirement in criterion 29.3.1.6 below). The criterion implies that the water should be suitable and safe for human consumption. Therefore compliance is dependent on the availability of documented evidence that these water supplies are regularly tested otherwise a PC rating should be applied.

Linked criteria:
1.2.2.3
10.2.1.7 and similar criteria in in-patient services.
22.2.1.3
23.2.1.3
24.2.1.3
29.6.1.1

29.3.1.6 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.

In many instances, the only alternative or backup water supply is either a borehole or reservoir tanks. The capacity of these tanks varies and their ability to meet the hospital's needs – in terms of duration – depends on the ratio of tank size to the rate of consumption. Also take note of the requirement of having these alternative sources tested for quality.

These plans need to consider the various scenarios based on local circumstances. For example where a reservoir tank is the only alternate source, there needs to be a system in place to ensure that there is some form of immediate warning when there is a failure of the primary supply, so that rationing can be implemented while the tank is still full. In addition plans need to be documented with regard to refilling the tank in the event of a prolonged breakdown in the normal supply. This could be done using a water tanker (by arrangement with the local fire department, town council, Water Utilities Corporation, etc.).

29.3.1.7 Relevant personnel are trained to ensure that all operations to secure safe water are properly performed.

Where necessary, any operations pertaining to the changeover to the emergency water supply are handled by the organisation's technical personnel (maintenance department). In smaller institutions however, where technical backup may be limited, suitable persons need to be identified and trained in the procedures to be followed. Such training needs to be held at regular intervals and must be fully documented.

29.3.1.8 All water supplies are tested and the results are documented on a regular basis.

Regardless of whether tests are conducted in-house or by contracted water treatment specialists, records of such tests should be available. This should include microbiologic testing.

Note that testing also applies to the water used for steam boilers to ensure that it will not cause corrosion and pitting of the shell. The water would then be dosed if necessary, as determined by the test results.

29.4 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/coordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) percentage of backlog in repairs
b) number of call backs (repeat-repairs)
c) number of preventative maintenance inspections done
d) number of call-outs
e) downtime on equipment/plant/machinery
f) personnel productivity indexes
g) number of negative incidents
h) number of operator errors, and
i) compliance to periodic operator maintenance schedule.

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.

29.4.1 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.

Once the maintenance service has analysed its mission, defined its objectives, and identified all its stakeholders, there needs to be a way in which progress towards achieving these objectives can be measured.

The minimum requirement for considering compliance will be the availability of evidence of:

- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

29.4.1.2 Indicators of performance are identified, to evaluate the quality of the service.

Performance indicators are quantifiable measurements that are used to monitor the performance of the department in carrying out its operational responsibilities. Examples could include:

1. *Percentage of backlog in repairs*
2. *Number of call backs (repeat-repairs)*
3. *Number of preventative maintenance inspections done*
4. *Number of call-outs*
5. *Downtime on equipment/plant/machinery*
6. *Personnel productivity indexes*
7. *Number of negative incidents*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

Regular measurements should be done to check on the performance indicators as above and these results will allow for ongoing monitoring of either poor performance

against the standards, or improvements over time. On-going monitoring is required in order to demonstrate that improvements are being sustained.

29.5 Prevention and Control of Infection

29.5.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

29.5.1 Criteria

29.5.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes

Linked criterion:
9.2.1.1

29.5.1.2 Infection control processes include prevention of infection by using appropriate protective clothing in high risk clinical areas.

29.5.1.3 Infection control processes include effective hand washing procedures.

29.6 Risk Management

29.6.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

29.6.1 Criteria

29.6.1.1 The department conducts ongoing monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, personnel and visitor related risks, financial, legal risks, physical facility, security and environmental risks, etc as a result of matters pertaining to the Maintenance Service should be included.

Following an initial formal risk identification and assessment process, the monthly workplace inspection can be utilised to augment the process, but this should not replace the routine day to day risk-related activities associated with such department.

Linked criteria:
7.1.1.1
29.1.1.4, 29.2.1.1, 29.2.1.2, 29.2.1.6, 29.2.2.1, 29. 2.2.4, 29.2.3.2, 29.3.1.1, 29.3.1.4, 29.3.1.5

29.6.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation at departmental level, in the facility's overall system of the monitoring of negative incidents, will be evaluated.

Analysed data, with responses/remedial action are required.

Linked criteria:
7.1.1.7, 7.2.6.4

29.6.1.3 Security measures are in place and are implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated

Linked criteria:
7.4.1.4

29.6.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criteria:
7.5.1.1

29.6.1.5 Organisation policy on handling, storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of healthcare waste.

Linked criteria:
7.7.1.1

SE 30 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, who should provide resuscitation and at what level, the skills, training and competence of personnel required, and the availability of equipment.

To facilitate the provision of effective resuscitation, relevant equipment must be readily available, checked and functional. The medical equipment manager is, therefore, an essential member of the team.

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 – the focus ought to be on early identification of adverse events, prediction, 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 physiologic 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 provide early specialist critical care to those patients with unequivocal physiological instability or significant hospital personnel concern for patients in a non-critical 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.

Considerable research and consultation preceded this updated version of standards for the provision of effective resuscitation systems within a healthcare organisation.

Standards

30.1 Resuscitation Committee

30.1.1 A resuscitation committee coordinates the management of resuscitation equipment, procedures, training and audit systems.

Standard Intent

Resuscitation equipment and procedures need to be uniform throughout the organisation. This requires:

- coordination among those who provide and maintain the equipment
- training (initial and on-going) of personnel to carry out procedures and to use the equipment
- ensuring the availability of the required equipment
- maintaining and monitoring equipment and
- ensuring that required drugs are available.

A competent individual who has the necessary knowledge and expertise with regard to resuscitation and the equipment required provides this coordination. The resuscitation co-ordinator should be a registered healthcare professional with at least Basic Life Support (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 are identified, documented and acted upon. Each organisation identifies 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 organisation.

The person(s) providing the training must be currently registered/accredited with a recognised body, as a resuscitation trainer, Training in many instances can be outsourced.

30.1.1 Criteria

30.1.1.1 The organisation establishes a resuscitation committee to advice on the required resuscitation equipment and procedures.

This criterion requires that a committee be formed to oversee all matters relating to resuscitation within the organisation. It is recommended that nurses as well as medical practitioners, preferably with experience in theatre / ICU / emergency care are included. This committee can be combined with other committees e.g. the Medical Equipment Management Committee.

Linked criterion:
1.2.8.1

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

The responsibilities of each committee member must be documented to clarify the roles of the different members and to ensure accountability.

Linked criterion:
2.3.1.1

30.1.1.3 A suitably qualified and experienced health professional is appointed as the resuscitation co-ordinator.

The resuscitation co-ordinator should be a registered health-care professional with at least Basic Life Support (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.

Linked criterion:
1.3.1.1

30.1.1.4 The medical equipment co-ordinator is on the committee.

The person responsible for the Medical Equipment Management Service ***(Service Element 31)****– i.e. the coordination of all matters relating to the procurement, management and maintenance of medical equipment – is appointed to the committee to ensure that all the requirements pertaining to the safe functioning and maintenance of all resuscitation-related devices are met.*

Linked criterion:
31.1.1.2

30.1.1.5 A person, designated to be a resuscitation coordinator, provides information, instruction and training on resuscitation to the personnel of the organisation.

This person(s) providing the training must be currently registered /accredited, with a recognised body, as a resuscitation trainer. Training in many instances can be outsourced. .

Linked criterion:
2.2.1.4

30.1.1.6 The committee checks and documents that systems for the provision of emergency power are regularly checked.

The resuscitation committee must satisfy itself that the standby-generator(s) and/or any other emergency power sources are tested by the responsible persons.

Batteries in defibrillators and spare batteries must be checked and maintained as per the manufacturers' recommendations.

Linked criteria:
29.2.1.6, 29.3.1.4

30.1.1.7 The committee checks and documents that system for the supply of gases and vacuum are regularly checked.

The resuscitation committee must satisfy itself that the vacuum and oxygen supplies are tested by the responsible persons.

Linked criterion:
29.2.2.4

30.1.1.8 A member of the resuscitation committee visits (at least monthly) all clinical departments, where resuscitation equipment is used, to monitor all aspects relating to resuscitation and equipment.

There should be documented evidence in all clinical departments of this activity. Reports on any discrepancies, together with recommendations for improvement, should also be available at departmental level.

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

Documented evidence will be required to substantiate compliance. Records also need to be kept of any remedial or quality improvement actions taken, as a result of any discrepancies found during the visit.

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

Written policies and procedures should be available that relate to the aspects mentioned in this criterion. Evidence of implementation of all of these are required for a compliance rating, otherwise this criterion will be scored PC.

Linked criteria:
1.2.6.1
31.1.1.6

30.2 Equipment and Medications

30.2.1 Essential resuscitation equipment and medications are available for each patient care area.

Standard Intent

The resuscitation committee ensures that the correct equipment is available for resuscitation. This requires agreeing to and listing those items of equipment deemed to be necessary for resuscitation.

A resuscitation trolley should be available within 1 minute of any patient. The resuscitation committee or equivalent ensures that each patient care area has access to a defibrillator or automated external defibrillator (AED) within 3 minutes of any collapsed patient.

Resuscitation equipment, with paediatric sizes where applicable, includes at least:

- A defibrillator with adult paddles/pads (and infant paddles/pads where

applicable)
- An ECG monitor
- A CPR board (if required e.g. not required for certain types of beds such as ICU or certain trauma beds)
- Suction apparatus (electrical and/or alternative) plus range of soft and hard suction catheters
- A bag-valve-mask manual ventilator
- Range of endotracheal tubes and 2 laryngoscopes with a range of straight and curved blades, spare batteries, spare globes, where applicable
- Introducer /stylet for endotracheal intubation
- Syringe to inflate ETT cuff
- Oropharyngeal tubes
- Equipment to perform an emergency cricothyroidotomy, either by needle or surgically.
- Appropriate facilities for intravenous therapy and drug administration (including paediatric sizes)
- Medication for cardiac arrest, coma, seizures, anaphylactic shock etc. (including paediatric doses) and
- Intravenous fluids, including plasma expanders.

Members of the committee, 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 are maintained. Documented policies and procedures, detailing what these checks will encompass and who will be responsible for their implementation, should be in place. Documented policy and procedures as well as evidence in the form of a visitation logbook or similar record system are required.

Proper checklists need to 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.

30.2.1 Criteria

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

National guidelines will apply.

Linked criteria:
1.2.2.2 and 3
31.2.1.2

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

Critical criterion

A resuscitation trolley should be available at the point of need within 1 minute.
The resuscitation committee or equivalent ensures that each patient care area has access to a defibrillator or automated external defibrillator *(AED) within 3 minutes of*

any patient collapsing.

Linked criteria:
1.2.2.2 and 3
10.2.1.4 And similar criteria in in-patient services i.e. SEs 11 to 16 and 40
17.2.3.1
22.2.3.1
23.2.2.2
24.2.3.1

30.2.1.3 The committee checks and documents that resuscitation equipment and drugs are checked daily, or immediately after use by persons identified to be responsible for this.

Refer to statement of intent. Such documentation can be kept by the committee or at department level or both.

30.3 Education and Training

30.3.1 All personnel are suitably trained and educated to provide resuscitation and competencies are regularly measured.

Standard Intent

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

The standards do not specify levels of training as this will be decided on by management and included in the policy framework/continuing education strategy. Every person employed in a hospital should be trained in, at least, basic CPR and their on-going competence tested at intervals specified in facility policy.

Evidence of training of different levels of personnel is required to assess compliance. It is recommended that 80% of the clinical personnel complement on duty in patient care units have been trained.

30.3.1 Criteria

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

Root criterion

See intent statement.
Compliance will be assessed on analysed data indicating the percentage of the various categories of clinical and non-clinical personnel trained.

Linked criterion:
2.4.3.1

30.3.1.2 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.

Documented evidence of attendance at formal courses, training sessions and seminars on resuscitation needs to be kept on file for all members of the resuscitation committee, as well as all "relevant" personnel as identified by the organisation.

Relevant personnel would include the resuscitation trainers, who are required to update their skills and registration on a regular basis.

30.3.1.3 New healthcare professionals employed in clinical wards/units are provided with resuscitation training within one month of appointment.

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

Linked criterion:
22.1.1.5

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

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

Critical criterion

Linked criterion:
2.4.2.5

30.4 Quality Improvement

30.4.1 A formalised proactive quality improvement approach is maintained in the resuscitation service.

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/coordinating quality improvement structures/ or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) Clinical audits on resuscitations performed and documented evidence of remedial actions undertaken;
b) Progress made in the number of staff trained according to the education strategy;
c) Monitoring adherence to policies and procedures with regard to daily checking of the emergency trolleys;
d) Monitoring the frequency and causes of adverse events related to the operations of the resuscitation service;
e) Monitoring the frequency of resuscitations and why these patients were not identified pre-arrest; and
f) 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; and
- 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.

30.4.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit and*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

30.4.1.2 Indicators of performance are identified, to evaluate the quality of the service.

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits. These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings,

or specialised investigative studies. An indicator, in this context, is a measure used to determine improvements in clinical care over time.

Examples:

- *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 information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

30.4.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level.

Where the documentation (patient record) audit is a hospital-wide multidisciplinary process, that includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.
Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

SE 31 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 29) is responsible for all non-medical equipment.

Healthcare organisations establish appropriate medical equipment management structures and processes, to ensure improved healthcare delivery. Improved healthcare delivery includes the provision of safe, affordable, appropriate, effective and sustainable healthcare technology.

Where there is an in-house clinical engineering department/medical equipment workshop, the organisation has direct access to adequate (i.e. according to the needs of the organisation) suitably qualified/trained technical support from this source. Where there is no in-house clinical engineering practitioner, the organisation has ready access to suitably trained technical support from an external source or an appropriately contracted and suitable service provider in accordance with the organisation’s policy.

The management of equipment needs to be coordinated throughout an organisation and therefore an advisory committee needs to be formed. When new technology is planned, the committee needs to advise on the available facilities and on the competence of the personnel with regard to its age and maintenance, integration, interfacing, user training, storage and disposal.

The committee should be coordinated by an appropriately experienced person. The advisory committee needs to collaborate with other committees, such as theatre, infection control, resuscitation, health and safety and quality improvement. Meetings of the advisory committee are held on a regular basis and are minuted. The committee is also responsible for ensuring that risk management and quality assurance/improvement processes are formulated and implemented on an ongoing basis andthat regular training is provided on the safe and correct usage of all medical equipment utilised within the institution.

Medical equipment management includes compiling an inventory, conducting regular inspections, performing tests, conducting preventative and corrective maintenance. The effectiveness of medical equipment management is dependent on the knowledge and skills of those professionals qualified to provide the equipment management service andalso of those who use the equipment.The medical equipment maintenance manager implements programmes for training and education.

Managers in each patient care unit 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 that they are expected to use in the performance of their duties. This requires collaboration between organisational management, clinical leaders and those responsible for medical equipment management and technical support. Those

persons who finance, order, receive, maintain, repair and use medical equipment need to be included in the collaborative process.

Standards

31.1 Medical Equipment Support

31.1.1 Adequate human resources are available for the Medical Equipment Management Services (MEMS) to ensure safety and the correct management, usage and operation of medical equipment.

Standard Intent

Healthcare organisations have a responsibility to ensure, that appropriate medical equipment is available and ready for use at all times. Suitably qualified or trained individuals take responsibility for ensuring the provision, maintenance, checking and servicing of medical equipment. These responsibilities are defined in writing.

There is an accountable systematic approach to ensure 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 organisation, 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 or
- a medical equipment management and maintenance service at a national or district level or
- 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 are developed in line with current legislation and include the acquisition, allocation, utilisation and technical support for MEMS.

- Policies and procedures relating to the acquisition of equipment include technical support requirements and spares, regulatory compliance (compliance with IEC (International Electrotechnical Commission) and other international and/or national standards and where are applicable for the equipment under consideration.
- Policies and procedures for equipment acquisition also consider compatibility with other equipment suitability for the stated clinical function(s), life cycle costing/cost of ownership, supplier evaluation, past experience and accessories.
- Policies and procedures relating to deployment of equipment include availability and preparation of facilities, installation and commissioning, safety checks, final acceptance checks, connectivity, integration, interfacing, user training and storage and usage of disposables/consumables with limited shelf life.

Where the organisation employs its own clinical engineering personnel (an in-house clinical engineering department) the medical equipment manager would 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 institution concerned.

For the purposes of this document, the description "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 organisation's internal description for such a facility or service.

The onus is on the organisation's management to ensure that personnel are suitably qualified/competent and that CEDs are appropriately equipped to perform all functions expected of them. This should be according to any requirements as may be laid down by legislation and/or included in guidelines provided by relevant standards organisations and/or recognised professional bodies.

Large tertiary level institutions 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). 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 mere CE presence the main functions of which would be to handle first line emergencies, implement risk management, monitor the activities of outside service providers and be involved 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 is responsible for ensuring the safety, correct management, usage and operation of the medical equipment within the institution concerned.

31.1.1 Criteria

31.1.1.1 A medical equipment maintenance manager is designated by the organisation.

The person appointed under this criterion needs to have a level of competence/qualification as determined by national arrangements. Compliance is to be assessed against the post-specifications/requirements. The organisational framework with regard to personnel establishment and organogram will reflect such a position.

Linked criteria:
1.3.1.1
2.2.1.1
2.5.1.1

31.1.1.2 The responsibilities of the medical equipment maintenance manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.

Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1
30.1.1.4

31.1.1.3 A multidisciplinary advisory committee is appointed to represent managers, clinical and technical personnel involved in the management and use of medical equipment.

Root criterion for the following criteria

Linked criterion:
1.2.6.1, 1.2.8.1
38.3.2.1

31.1.1.4 Members of the committee are appointed in writing based on their competence in the area of healthcare technology management.

In most instances nursing and managerial personnel would have had little or no training with regard to healthcare technology. The next best option would therefore be those who have had a fair amount of experience in dealing with medical equipment such as theatre or ICU sisters and radiographers.

31.1.1.5 The responsibilities of the committee are documented.

Responsibilities include:
a) supervision of the technology/medical equipment life cycle, which include the following phases:

- *assessment and selection*
- *procurement*
- *commissioning*
- *monitoring ongoing utilisation (i.e. risk management, maintenance, user training etc.)*
- *de-commissioning (condemning).*

b) liaison with the manufacturers/suppliers/service providers.
c) external provider cost control and contract management.
d) advising on medical equipment management related activities, including risk management and quality improvement.

31.1.1.6 The committee meets regularly to discuss and advise on issues relating to healthcare technology management and these meetings are minuted.

Linked criterion:
30.1.1.10

31.1.1.7 The committee has ready access to a reliable source of expertise relating to healthcare technology.

The source and method of access needs to be documented.

31.2 Medical Equipment Management

31.2.1 Medical equipment is managed and maintained throughout the organisation.

Standard Intent

To ensure that medical equipment is available for use and is functioning properly the organisation:

- performs an audit on available medical equipment
- takes 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.
- conducts regular inspections of medical equipment
- tests medical equipment, as appropriate to its use and requirements and
- provides for a preventive maintenance plan.

Equipment is inspected and tested when new and then on an ongoing basis as appropriate to the age and use of the equipment or based on the manufacturer's instructions. Inspections, testing results and any maintenance are documented. This helps to ensure the continuity of the maintenance process and helps when capital planning for replacements, upgrades and other changes is being undertaken.

31.2.1 Criteria

31.2.1.1 An audit of medical equipment is conducted.

This documented audit should include all equipment currently in use in terms of:
a) assessment of appropriateness of equipment e.g. medical grade versus home use
b) availability of commissioning certificates
c) availability of owner's and service manuals
d) age and physical condition
e) current position in the technology life-cycle
f) suitability for its intended function
g) risk profile (based on service/ repair history) and
h) extent of its projected life expectancy.

Linked criteria:
1.2.2.3
3.1.1.8

31.2.1.2 There is a comprehensive inventory of all medical equipment which lists equipment type, make, model, serial number, location and supplier/service provider, date of purchase and service requirements.

There should be a coordinated process to ensure that all new equipment is added to the inventory.

Linked criterion:
30.2.1.1

31.2.1.3 Operator and/or service manuals are available to operators and technicians at all times.

31.2.1.4 Initial commissioning records are available for all high-risk medical equipment which include details of tests performed and training given.

High risk equipment includes:

- *anaesthetic machines and ancillary equipment*
- *defibrillators and other resuscitation equipment*
- *ventilators and other respiratory devices (including medical gas supply systems and ancillary equipment)*
- *suction equipment (including vacuum pipeline systems and ancillary equipment)*
- *critical monitoring and diagnostic equipment*
- *infant incubators and ancillary equipment such as oxygen monitors, temperature alarms, apnoea monitors etc.*
- *infusion therapy devices*
- *electrosurgical units (ESU) and other surgery related devices; and*
- *lasers.*

The above list is by no means complete, but serves as a guide to the more commonly used types of equipment that fall within the high-risk category.

31.2.1.5 The organisation plans and implements a planned preventative inspection and maintenance system according to the service requirements specified by the manufacturers.

Critical criterion

Regardless of whether the medical equipment is being maintained by an in-house CED or an external service provider a properly implemented maintenance management system must be in place.

This system must be capable of providing:

a) a schedule indicating when the prescribed Inspection/Preventative Maintenance (IPM) procedures are due
b) a record of when procedures or repairs were carried out and by whom
c) a description of what was done and a list of parts replaced or fitted
d) detailed results of any qualitative and/or quantitative tests performed
e) a description of the various tasks, procedures and any measurements or observations that need to be performed for each inspection/planned maintenance and
f) a means of "flagging" recurring and/or critical problems for risk management purposes.

Although computerised systems can make reporting and risk management easier, a properly configured manual system will suffice, as long as the methods used for risk management are properly documented and that all job cards are properly indexed.

Linked criteria:
10.2.1.3 and similar criteria in in-patient services i.e. SEs 11 to 16 and 40
17.2.2.9
19.1.4.1

20.3.2.5
22.2.2.7
23.2.2.7
24.2.2.6

31.2.1.6 There is a service history for each piece of equipment which includes signed and dated job-cards detailing all procedures carried out parts fitted etc.

This refers to documented evidence of the implementation of 31.2.1.5.

The service history is a component of the organisation's medical equipment management programme and must be structured in such a way as to aid risk management processes.

Hardcopy evidence in the form of comprehensive, signed and dated job-cards needs to be available to support the record entries in the service history database.

The data collected must be of such a nature as to enable trends or failure patterns to be built up that will enable timeous safety interventions to be implemented.

31.2.1.7 Departmental managers have access to information on service and repairs of equipment.

31.2.1.8 A documented system, known to all relevant persons is in place which addresses the provision of basic technical support in first-line emergency situations.

The system needs to include:
a) the party/parties responsible for providing it (e.g. in-house, district or regional clinical engineering department, outside service provider or a combination of both
b) individual responsibilities in cases where support is provided from more than one source
c) the procedures that need to be followed in order to obtain assistance
d) documented records of all call-outs and
e) properly completed incident reports where necessary.

Linked criteria:
1.2.2.4
17.2.3.3
29.1.2.4

31.2.1.9 Advanced technical support is provided in emergency situations.

Contingency plans are in place in the event of the primary source (31.2.1.8) of support being unavailable or incapable of effecting repairs.

31.2.1.10 Names of specialist service contractors are available with their locations, telephone numbers and the responsible persons specified.

Linked criterion:
1.2.7.3

31.2.1.11 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.

The equipment and consumables required would depend, to a large degree on the department's level of involvement in the actual hands-on maintenance and repair procedures. However, in the case of high-risk devices such as defibrillators, a defibrillator analyser should really be available for testing purposes - regardless of who carries out the maintenance.

Other test equipment should include measuring devices for gas pressure and flow, temperature and electronic test equipment according to the level of involvement.

Certain devices may require specialised test equipment, normally supplied by the manufacturer. In some cases, this is only provided after successful completion of a training course.

Linked criteria:
1.2.2.3
3.3.1.2

31.2.1.12 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.

Linked criteria:
38.3.2.2
39.3.3.1

31.2.1.13 Where there are in-house clinical engineering personnel a system exists for them to obtain information on medical device hazard alerts or safety bulletins, on which they act as appropriate.

Medical device alerts or safety bulletins are usually electronically published alerts that relate to incidents and/or malfunctions that have occurred involving medical devices or equipment with the aim of alerting users of similar equipment and thus preventing a recurrence.

In most instances, manufacturers will alert users of potential hazards or conduct product recalls via their sales/service agents. However, due to the variety, nature and number of adverse events that can occur the onus rests on the owner of the equipment to report such occurrences to the relevant manufacturer and/or official agency.

In the interests of safety the owner should have policies and procedures in place that dictate how the monitoring of medical device alerts will be done and who will be responsible.

More information on device alerts may be obtained from the websites of the Federal Drug Administration (FDA) in the USA (http://www.fda.gov) and the Medical Devices Agency (MDA) in the UK (http://www.medical-devices.gov.uk).

Also from www.whoint/medicaldevices; www.ceasa-national.org.za

A pay subscription service is also available from ECRI in the USA in the form of their "Health Device Alerts" publication. Information on the costs involved may be obtained from their website.
http://www.ecri.org

31.3 Personnel Training

31.3.1 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. Also those ancillary personnel who impact on technology utilisation and/or availability (e.g. stores department personnel) should receive basic appropriate training, which may include identification of medical equipment, devices, accessories and common spare parts.

All personnel need to be trained in risk management, infection control and resuscitation. Those persons involved in medical equipment management participate in the organisation's in-service training programme on these issues and also ensure, that education and training are provided, which is specific for their own department.

The organisation has a responsibility to facilitate professional development and competence of its personnel in matters relating to medical equipment management and personnel have a responsibility to maintain their own competence and current knowledge.

31.3.1 Criteria

31.3.1.1 Training is provided for all users of basic medical equipment with a record of all such training given and successfully completed.

The users of medical equipment include personnel in all the relevant clinical departments such as the operating theatre, critical care and emergency units.

In order for this criterion to be assessed as compliant documented evidence must be provided that at least 80% of relevant personnel have been trained.

Linked criterion:
2.4.2.2
7.3.1.5

31.3.1.2 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.

The users of medical equipment include personnel in all the relevant clinical departments such as the operating theatre, critical care and emergency units. Complex/critical life support equipment refers to devices such as defibrillators, ventilators, infusion pumps, anaesthetic machines, cardiac monitors, heart-lung machines, etc.

In order for this criterion to be assessed as compliant documented evidence must be provided that at least 80% of relevant personnel have been trained and found to be competent.

Linked criteria:
2.4.2.2, 2.4.2.5

31.3.1.3 All users of medical equipment are provided with training in basic infection control and decontamination procedures.

Linked criterion:
31.6.1.1

31.3.1.4 Training in basic electrical safety is provided to all personnel involved in the use of electrically operated equipment.

Linked criterion:
2.4.2.2

31.3.1.5 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.

Linked criterion:
2.4.2.2

31.3.1.6 Where clinical engineering personnel are employed, they are encouraged and assisted by management to attend seminars, congresses, conferences and training sessions which could improve their knowledge of and proficiency in medical technology matters.

Linked criteria:
2.4.3.3 and 4

31.4 Equipment Safety

31.4.1 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

Personnel ensure that equipment is tested and maintained in a safe working environment. Risk management includes identifying possible hazards to both patients and personnel and formulating and implementing processes or procedures that could minimise the risks associated with these hazards. Those working with equipment are responsible for ensuring that the environment is safe.

Such hazards can arise from faulty or out-of-calibration equipment or user error 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 organisation 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. 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.

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 country-specific legislation. To this end personnel need to 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 reactions and incompatibilities, spill, leak and disposal procedures, protective measures required for safe handling and storage).

Copies of relevant acts and regulations would include those controlling the occupational health & safety, the hazardous substances and environment conservation.

31.4.1 Criteria

31.4.1.1 Clinical engineering personnel implement risk management processes in terms of the organisational risk management systems.

Root criterion

The system should be linked to the medical equipment management programme and incorporate the means to flag recurrent failures, etc. as part of a structured risk management system.

Linked criteria:
1.2.2.3
31.7.1.1

31.4.1.2 There is an adequate scavenging system for the removal of nitrous oxide and volatile anaesthetic agents in the medical equipment workshop.

31.4.1.3 Where anaesthetic vaporisers are tested and serviced in the workshop a suitable fume extraction chamber is provided.

31.4.1.4 Where extensive soldering work is undertaken, soldering stations are provided with a suitable fume extraction system.

This would only apply to workshops where extensive soldering work is carried out e.g. daily component level replacement or repairs, or where there are a number of soldering stations in one area.

31.4.1.5 Where volatile cleaning agents are used an appropriate fume extraction chamber is provided for the safe dispersal of hazardous vapours, e.g. ether.

31.4.1.6 The medical equipment workshop has adequate 15 ampere surge-protected electrical power outlets.

31.4.1.7 The medical equipment workshop is fitted with air-conditioning capable of maintaining a year-round constant temperature of 21 degrees C.

The reason for this requirement is that certain equipment needs to be calibrated at constant temperatures in order to be able to achieve consistent and accurate readings during any subsequent procedures.

31.5 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/coordinating quality improvement structures/ or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

Quality monitoring could include:

a) frequency and duration of use
b) user acceptance
c) user training and training evaluation
d) equipment downtime
e) number and type of faults, failures, incidents and
f) Cost-effectiveness.

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 and
- graphed and/or tabled results, as appropriate.

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

31.5.1 Criteria

31.5.1.1 There are formalised quality improvement processes for the service that is developed and agreed upon by the personnel of the service.

Once the medical equipment management service has analysed its mission, defined its objectives and identified all its stakeholders, there needs to be a way in which progress towards achieving these objectives can be measured.

The minimum requirement for considering compliance will be the availability of evidence of:

- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

31.5.1.2 Indicators of performance are identified, to evaluate the quality of the service.

Performance indicators are quantifiable measurements, determined beforehand, that will reflect the quality of the service or department.

Performance indicators could include:
a) number or % of "call backs" (repeat repairs);
b) repair turn-around times of in-house and/or external technical support;
c) cost analysis of in-house and/or external technical support; and
d) number or % of equipment failures and user errors.
The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

Regular measurements should be done to check on the performance indicators as above and these results will allow for on-going monitoring of either poor performance against the standards, or improvements over time. On-going monitoring is required in order to demonstrate that improvements are being sustained.

31.6 Prevention and Control of Infection

31.6.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

31.6.1 Criteria

31.6.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root criterion
The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.
Linked criterion:
9.2.1.1
31.3.1.3

31.6.1.2 Infection control processes includes prevention of infection by using appropriate protective clothing in high risk clinical area.

31.6.1.3 Infection control processes include effective hand washing procedures.

31.7 Risk Management

31.7.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational processes for risk management (Service Element 7).

31.7.1 Criteria

31.7.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in their department. Such documentation must form part of the organisation wide risk management processes. All relevant aspects and services of the department, e.g. patient, personnel and visitor related risks, financial, legal risks, physical facility, security and environmental risks, etc should be included.

Linked criterion:
7.1.1.1
31.4.1.1

31.7.1.2 A system for the monitoring of negative incidents/near misses/ adverse (sentinel) events is available which includes the documentation of interventions and responses to recorded incidents.

Participation at department level, in the facility's overall system of the monitoring of negative incidents/near misses/adverse events will be evaluated.

Equipment-related incidents (ERIs) also fall under the broad heading of adverse events. An ERI is therefore an adverse event that has involved a medical device. It includes equipment failure, malfunction or user error relating to such devices.

Knowing the difference between a genuine equipment failure and user error is important to both the risk management process and the minimisation of the possibility of adverse events or equipment-related incidents.

A means of "flagging" equipment failures (both actual and alleged) should be incorporated into the system and the failures should also be categorised according to:
a) cause – e.g. device failure, accessory failure, user error/negligence etc.
b) severity – e.g. fatal, life threatening, serious injury, minor injury, patient discomfort, no negative outcome,
c) situation – e.g. failed in use, failed pre-use test, failed calibration, failed IPM etc.,
d) action taken – e.g. repaired in-house, sent to agent, condemned, user training etc.

Analysed data, with responses/remedial action related to departmental incidents are required.

Linked criteria:
7.1.1.7, 7.2.6.4

31.7.1.3 Security measures are in place and implemented to safeguard and protect personnel.

The department's participation in the facility's overall security plan will be evaluated

Linked criterion:
7.4.1.4

31.7.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

31.7.1.5 Organisation policy on handling, segregation, storage and disposal of waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, segregation, collecting, storing and disposing of healthcare waste.

Linked criterion:
7.7.1.1

SE 32 PHYSIOTHERAPY SERVICE

OVERVIEW OF THE PHYSIOTHERAPY SERVICE

A healthcare organisation'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, planning and delivery of care
- monitoring and evaluating the results of the care provided for each patient and
- adapting and implementing care plans according to the patients' changing needs.

A care plan is not sufficient to achieve optimal outcomes unless the delivery of services is co-ordinated and monitored. Therefore, a healthcare organisation needs to consider the care it provides as part of an integrated system of services. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. The organisation needs to ensure that scarce professional resources are used optimally, e.g. supervising/managing non-professional members of the health team and monitoring the care that they provide. Processes for continuity and coordination of care among the members of the multi-disciplinary/interdisciplinary team must be implemented in and between services and networking organisations.

This chapter is designed to enable the staff in the physiotherapy service to assess, monitor and improve the quality of care in their own service. The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and needs to comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

Standards

32.1 Management of the Service

32.1.1 The physiotherapy service is managed to ensure the provision of a safe and effective service.

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performance requires clear leadership from a suitably qualified individual. The responsibilities of each staff member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement.

Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

32.1.1 Criteria

32.1.1.1 A designated individual is responsible for the physiotherapy service.

This refers to a person appointed to the management position in terms of qualification and job specifications.

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.
Where there is no job specification, this will be scored NC.

Linked criteria:
1.2.7.2, 1.3.1.1,
2.2.1.1, 2.5.1.1

32.1.1.2 The physiotherapy service manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

Linked criteria:
1.2.6.1
32.3.1.1

32.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisational chart, which reflects the persons required to provide an adequate service for the facility. However, where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criteria:
1.1.1.2
2.2.1.4

32.1.1.4 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.
Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

32.1.1.5 The manager ensures that there is a documented welfare programme in place for the staff within the department.

32.2 Facilities and Equipment

32.2.1 The service has adequate facilities and serviceable equipment to meet the treatment needs of the population served.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure, that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

32.2.1 Criteria

32.2.1.1 There is adequate space for physiotherapists to treat patients effectively.

Root criterion for criteria 32.2.1.3 and 32.2.1.4

The requirements will vary according to the size of the facility, the number of physiotherapists and the services provided. There should be adequate waiting space for clients/patients, a gymnasium, private treatment areas, administrative space and storage space for records and equipment.

Linked criterion:
1.2.2.2

32.2.1.2 Adequate and relevant equipment and consumables are available to provide an effective service.

The requirements will vary according to the size of the facility, the number of physiotherapists and the services provided. Equipment could include plinths, parallel bars, an upright mirror, and electro therapy equipment.

Linked criterion:
1.2.23

32.2.1.3 There is adequate space for the storage of equipment and consumables.

32.2.1.4 Privacy is ensured through private cubicles, curtains or screens.

Critical criterion

Linked criteria:
1.2.5.1
5.2.1.1 and 2
6.1.2.1

32.3 Policies and Procedures

32.3.1 Policies and procedures guide the management and patient care in the department.

Standard Intent

As indicated in 32.1.1, departmental policies and procedures are essentiall. They give the personnel the guidance they require to carry out the functions of the department. It is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need to be authorized by the organisational leaders.

Clinical policies and procedures guide professional personnel in providing uniform care to patients. Clinical guidelines are frequently helpful and may be included in the care process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

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 and
- high-risk patients and procedures.

Policies and procedures should focus on the following: e.g.

- referral systems
- assessment methods
- high risk patients
- treatment protocols and
- treatment techniques and equipment.

32.3.1 Criteria

32.3.1.1 Policies and procedures that guide the personnel in the management and clinical aspects of the physiotherapy service are available and implemented.

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the physiotherapy service with other services in the formulation of policies should be sought, e.g. systems for referring patients from other departments to the physiotherapy service.
Physiotherapy-specific policies could include policies relating to the number of personnel required and their qualifications; professional development; peer reviews; hours during which the service is operational; referrals to outside organisations; keeping statistics; assessment of patients; any interventions/procedures performed.

Linked criterion:
32.1.1.2

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

32.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel.

32.3.1.4 Each policy and procedure is reviewed as per organisational requirement. (Frequency of the review).

32.4 Coordination of Patient Care

32.4.1 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 the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means according to appropriate policies determined by the organisation. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case management).

The patient, family and others are included in the decision process when appropriate.
The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team and is made available to all relevant

caregivers who are authorised to have access to its content.

Establishing goal-orientated rehabilitation in a general hospital setting can be very difficult. One of the two models below may be used, or they may be combined:

1. Multidisciplinary 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, 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 multidisciplinary team
- the establishment of achievable goals
- patient participation to reach those goals
- this should result in the person reaching his/her potential and
- outcomes need to be measured/demonstrated.

32.4.1 Criteria

32.4.1.1 There is a multidisciplinary/interdisciplinary approach to the development and implementation of a therapeutic programme.

Please note: this will never be NA, because there will always be team members as indicated in criterion 32.4.1.2.

Linked criteria:
1.3.2.1
32.4.3.1

32.4.1.2 The team consists of appropriately qualified personnel, including representatives from the medical, nursing, social work, physiotherapy, occupational therapy, clinical psychology and other disciplines, departments or services, as appropriate.

Linked criterion:
1.3.1.7

32.4.1.3 The team members' responsibilities include the development and implementation of a comprehensive, individualised care plan for each patient, based on the assessment of the patient.

This refers to the relevant forms/documents that need to be present in the patient's clinical record, as well as the completeness of entries made. For this purpose, the results ***of patient record audits*** *need to be taken into account.*

Linked criterion:
1.3.2.4

32.4.1.4 The team conducts periodic re-evaluation of each patient's care plan to determine whether established goals are being or have been met and whether change in the patient's condition requires modification of goals.

*This criterion is assessed by means of a **patient record audit.***

32.4.1.5 The team includes the patient and his/her family in the development and review of the care plan, as appropriate.

*Family meetings/discussions are of utmost importance and it is recommended that meetings/discussions are held on or shortly after admission, during rehabilitation and prior to discharge. This criterion is assessed by means of a **patient record audit.***

32.4.1.6 The multidisciplinary/interdisciplinary team meets regularly to co-ordinate patient care.

*This criterion is assessed by means of a **patient record audit.***

32.4.2 All patients treated by physiotherapists 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 will be modified to meet the needs of each patient.

Regular reassessments of patients ensure that the continuing care plans are suited to the needs of the patients and are essential to justify the treatment plans and on-going care.

32.4.2 Criteria

32.4.2.1 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

*Compliance will be verified during the **patient record audit,** which will focus on the legibility of signatures and the identification of designations/qualifications.*

Linked criterion:
2.5.1.1

32.4.2.2 The findings of assessments performed outside the organisation are verified on admission.

32.4.2.3 Patients are reassessed at intervals appropriate to their conditions, care plans, individual needs or according to organisational policies and procedures.

Critical criterion

*Compliance will be verified during the **patient record audit.***

- *Is there evidence of appropriate follow-up?*
- *Did the planned follow-up take place?*
- *Is the case closed or awaiting further action?*
- *Are interventions comprehensively documented?*

Linked criteria:
1.2.5.4
8.2.1.5

32.4.3 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 and standards of practice. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational 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 organisational resources. Once implemented, guidelines are 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.

32.4.3 Criteria

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

The provision of clinical guidelines is especially important if there is more than one physiotherapist and they have trained at different institutions. The aim is to ensure that assessments are planned to cover all relevant aspects and that the appropriate interventions take place. In the absence of guidelines this criterion will be scored NC.

*This criterion requires evidence of the implementation of/adherence to these guidelines and such evidence is obtained from **the results of clinical audits.***
This will be scored PC by default if there are no structured clinical audits to monitor the implementation of the guidelines.

Linked criterion:
32.3.1.1

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

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Linked criterion:
8.2.1.4

32.4.3.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

32.5 Patient and Family Education

32.5.1 Education supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to participate and make decisions on how to contionue with care at home.

Variables like educational literacy, beliefs and limitations are taken into account.
Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care they need to be educated.
It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient.

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

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

The service has a range of health promotion information materials and resources, specific to the particular patient population. Health information provided is recorded to ensure follow-up and to reduce medico-legal risks.

*Evidence of compliance is obtained from patient interviews as well as **patient record audits***

32.5.1 Criteria

32.5.1.1 Patients and families indicate that they have been informed about participation in the care process.

Root criterion

Compliance will be verified during patient interviews.

Linked criteria:
4.2.3.2
5.3.1.2

32.5.1.2 Patients and families indicate that they have been informed about any financial implications of care decisions.

Compliance will be verified during patient interviews.

Linked criterion:
4.2.3.3

32.5.1.3 Interaction between personnel, the patient and the family is noted in the patient's record.

*Compliance will be verified during the **patient record audit.***

Linked criterion:
5.3.1.2

32.5.1.4 When appropriate, patients and families indicate that they have been educated about the use of rehabilitation techniques.

Compliance will be verified during patient interviews.

32.5.1.5 When appropriate, patients and families indicate that they have been educated about the use of equipment.

Compliance will be verified during patient interviews.

32.6 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/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:
a) patient assessment
b) the success of physiotherapy procedures carried out
c) the availability, contents and use of patient record and
d) 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 and
- 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.

32.6.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:
- *at least one clinical audit*
- *participation in documentation (patient record) audit and*

- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

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

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings or specialised investigative studies. Measurable indicators must reflect processes related to the physiotherapy service. They should, therefore, focus on high-risk, high-volume or problem-prone conditions and measure both the processes and the outcomes of patient care.
Examples:
1. *the management of patient presenting with stroke, spinal cord injury, burns, chronic pain;*
2. *the implementation of clinical guidelines by means of structured clinical audits.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

32.6.1.4 A documentation audit system is in place.

Documented evidence of such patient record audits must be provided at departmental level. The score of this criterion needs to reflect the aggregated average score of all relevant criteria in this document.

Where the patient record audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

32.7 Patient Rights

32.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

32.7.1 Criteria

32.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

32.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

32.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

32.8 Prevention and Control of Infection

32.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

32.8.1 Criteria

32.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root Criterion

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

32.8.1.2 Infection control processes include prevention of the spread of communicable diseases.

32.8.1.3 Infection control processes includes prevention of the spread of infection through use of medical and rehabilitation equipment.

32.9 Risk Management

32.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

32.9.1 Criteria

32.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

32.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

32.9.1.3 Security measures are in place and implemented to ensure the safety of patients, staff and visitors.

The department's participation in the facility's overall security plan will be evaluated.

Linked criterion:

7.4.1.4

32.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

32.9.1.5 The organisation's policy on handling, storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of healthcare waste.

Linked criterion:
7.7.1.1

SE 33 OCCUPATIONAL THERAPY SERVICE

OVERVIEW OF THE OCCUPATIONAL THERAPY SERVICE

A healthcare organisation'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, planning and delivery of care
- monitoring and evaluating the results of the care provided for each patient and
- adapting and implementing care plans according to the patients' changing needs.

A care plan is not sufficient to achieve optimal outcomes unless the delivery of services is co-ordinated and monitored. Therefore, a healthcare organisation needs to consider the care it provides as part of an integrated system of services. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. The organisation needs to ensure that scarce professional resources are used optimally, e.g. supervising/managing non-professional members of the health team and monitoring the care that they provide. Processes for continuity and coordination of care among the members of the multi-disciplinary/interdisciplinary team must be implemented in and between services and networking organisations.

This chapter is designed to enable the staff in the occupational therapy service to assess, monitor and improve the quality of care in their own service. The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and needs to comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

Standards

33.1 Management of the Service

33.1.1 The occupational therapy service is managed to ensure the provision of a safe and effective service.

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each staff member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement. Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

33.1.1 Criteria

33.1.1.1 A designated individual is responsible for the occupational therapy service.

This refers to a person appointed to the management position in terms of qualification and job specifications.

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.
Where there is no job specification, this will be scored NC.

Linked criteria:
1.3.1.1, 1.2.7.2
2.2.1.1, 2.5.1.1

33.1.1.2 The occupational therapy service manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

Linked criteria:
1.2.6.1
33.3.1.1

33.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisational chart, which reflects the persons required to provide an adequate service for the facility. However where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criterion:
1.1.1.2
2.2.1.4

33.1.1.4 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.
Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

33.1.1.5 The manager ensures that there is a documented wellness programme in place for the staff within the department.

33.2 Facilities and Equipment

33.2.1 The service has adequate facilities and serviceable equipment to meet the treatment needs of the population served.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

33.2.1 Criteria

33.2.1.1 There is adequate space for occupational therapists to treat patients effectively.

Root criterion for criteria 3 and 4

The requirements will vary according to the size of the facility, the number of occupational therapists and the services provided. There should be adequate waiting space for clients/patients, private treatment areas, administrative space and storage space for records and equipment.

Linked criterion:
1.2.2.2

33.2.1.2 Adequate and relevant equipment and consumables are available to provide an effective service.

The requirements will vary according to the size of the facility, the number of occupational therapists and the services provided. Equipment could include adaptive equipment, standing frames, pulleys, wedges, an upright mirror, occupational therapy modalities, equipment to evaluate and treat cognitive dysfunction, etc.

Linked criteria:
1.2.2.3

33.2.1.3 There is adequate space for the storage of equipment and consumables.

33.2.1.4 Privacy is ensured through private cubicles, curtains or screens.

Critical criterion

Linked criteria:
1.2.5.1
5.2.1.1 and 2
6.1.2.1

33.3 Policies and Procedures

33.3.1 Policies and procedures guide the management and patient care in the department.

Standard Intent

As indicated in 33.1.1, departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

Clinical policies and procedures guide professional personnel in providing uniform care to patients. Clinical guidelines are frequently helpful and may be included in the process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

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.

Policies and procedures should focus on patients and procedures, e.g.

- referral systems
- assessment methods
- high risk patients and procedures
- treatment protocols and
- treatment techniques and equipment.

33.3.1 Criteria

33.3.1.1 Policies and procedures are available to guide the personnel in the management and clinical aspects of the occupational therapy service.

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the occupational therapy service with other services in the formulation of policies should be sought, e.g. systems for referring patients from other departments to the occupational therapy service.

Policies specific to occupational therapy could include policies relating to the number of personnel required and their qualifications; professional development; peer reviews; hours during which the service is operational; referrals to outside organisations; keeping of statistics; assessment of patients; any interventions/procedures performed, etc.

Linked criteria:
33.1.1.2

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

33.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all staff members.

33.3.1.4 Each policy and procedure is reviewed.

33.4 Coordination of Patient Care

33.4.1 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 the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means according to appropriate policies determined by the organisation. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers).

The patient, family and others are included in the decision process when

appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team and is made available to all relevant caregivers who are authorised to have access to its content.

Establishing goal-orientated rehabilitation in a general hospital setting can be very difficult. One of the two models below may be used, or they may be combined:

1. Multidisciplinary 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, 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 multidisciplinary team;
- the establishment of achievable goals
- patient participation to reach those goals
- this should result in the person reaching his/her potential
- outcomes need to be measured/demonstrated.

33.4.1 Criteria

33.4.1.1 There is a multidisciplinary/interdisciplinary approach to the development and implementation of a therapeutic programme.

Please note: this will never be NA, because there will always be team members as indicated in criterion 33.4.1.2.

Linked criterion:
1.3.2.1
33.4.3.1

33.4.1.2 The team consists of appropriately qualified personnel, including representatives from the medical, nursing, social work, occupational therapy, physiotherapy, clinical psychology and other disciplines, departments or services, as appropriate.

Linked criteria:
1.3.1.7

33.4.1.3 The team members' responsibilities include the development and implementation of a comprehensive, individualised care plan for each patient, based on the assessment of the patient.

*This refers to the relevant forms/documents that need to be present in the patient's clinical record, as well as the completeness of entries made. For this purpose, the results **of patient record audits** need to be taken into account.*

Linked criterion:
1.3.2.4

33.4.1.4 The team conducts periodic re-evaluation of each patient's care plan to determine whether established goals are being or have been met and whether change in the patient's condition requires modification of goals.

*This criterion is assessed by means of a **patient record audit.***

33.4.1.5 The team includes the patient and his/her family in the development and review of the care plan, as appropriate.

*Family meetings/discussions are of utmost importance and it is recommended that meetings/discussions are held on or shortly after admission, during rehabilitation and prior to discharge. This criterion is assessed by means of a **patient record audit.***

33.4.1.6 The multidisciplinary/interdisciplinary team meets regularly to coordinate patient care.

*This criterion is assessed by means of a **patient record audit.***

33.4.2 All patients treated by occupational therapists 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 will be modified to meet the needs of each patient.

Regular reassessments of patients ensure that the continuing care plans are suited to the needs of the patients and are essential to justify the treatment plan and on-going care.

33.4.2 Criteria

33.4.2.1 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

*Compliance will be verified during the **patient record audit,** which will focus on the legibility of signatures and the identification of designations/qualifications*

Linked criterion:
2.5.1.1

33.4.2.2 The findings of assessments performed outside the organisation are verified on admission.

33.4.2.3 Patients are reassessed at intervals appropriate to their conditions, care plans, individual needs or according to organisational policies and procedures.

Critical criterion

*Compliance will be verified during the **patient record audit.***

- *Is there evidence of appropriate follow-up?*
- *Did the planned follow-up take place?*
- *Is the case closed or awaiting further action?*
- *Are interventions comprehensively documented?*

Linked criteria:
1.2.5.4
8.2.1.5

33.4.3 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 organisational 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 organisational resources. Once implemented, guidelines are 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.

33.4.3 Criteria

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

The provision of clinical guidelines is especially important if there is more than one occupational therapist and they have trained at different institutions. The aim is to ensure that assessments are planned to cover all relevant aspects and that the appropriate interventions take place.

*This criterion requires evidence of the implementation of/adherence to these guidelines and such evidence is obtained from **patient record audits** and clinical audits.*

This will be scored PC by default if there are no structured clinical audits to monitor the implementation of the guidelines.

Linked criterion:
33.3.1.1

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

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem prone conditions is considered for auditing. If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Linked criterion:
8.2.1.4

33.4.3.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

33.5 Patient and Family Education

33.5.1 Education supports patient and family participation in care decisions and care processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care and continue care at home.
Variables like educational literacy, beliefs and limitations are taken into account.
Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care they need to be educated.

It is sometimes important that patients and families are made aware of any financial implications associated with care choices, such as choosing to remain an inpatient rather than being an outpatient. Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment. Community organisations that support health promotion and disease prevention education are identified and, when

possible, on-going relationships are established.

The service has a range of health promotion information materials and resources, specific to the particular patient population. Health information provided is recorded to ensure follow-up and to reduce medico-legal risks.

*Evidence of compliance is obtained from patient interviews as well as **patient record audits***

33.5.1 Criteria

33.5.1.1 Patients and families indicate that they have been informed about participation in the care process.

Root criterion

Compliance will be verified during patient interviews.

Linked criteria:
4.2.3.2
5.3.1.2

33.5.1.2 Patients and families indicate that they have been informed about any financial implications of care decisions.

Compliance will be verified during patient interviews.

Linked criterion:
4.2.3.3

33.5.1.3 Patients indicate that they have been informed about relevant high health risks, e.g. the safe use of medical equipment.

*Compliance will be verified during the **patient record audit.***

33.5.1.4 Interaction between personnel, the patient and the family is noted in the patient's record.

*Compliance will be verified during the **patient record audit.***

Linked criterion:
5.3.1.2

33.6 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/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:

a) patient assessment
b) the success of occupational therapy procedures carried out
c) the availability, contents and use of patient records
d) 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 and
- 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.

33.6.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit and*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

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

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies. Measurable indicators must reflect processes related to the occupational therapy service. They should, therefore, focus on high-risk, high-volume or problem-prone conditions and measure both the processes and the outcomes of patient care.

Examples:
1. *The management of patient presenting with hand injuries, stroke, spinal cord injury, burns, delayed milestones, psychiatric disorders, etc.*
2. *the implementation of clinical guidelines by means of structured clinical audits, etc.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

33.6.1.4 A documentation audit system is in place.

Documented evidence of such audits must be provided at departmental level. The score of this criterion needs to reflect the aggregated average score of all relevant criteria in this document.

Where the documentation audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.
Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

33.7 Patient Rights

33.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

33.7.1 Criteria

33.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

33.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

33.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

33.8 Prevention and Control of Infection

33.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

33.8.1 Criteria

33.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root Criterion

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes.

Linked criteria:
9.2.1.1

33.8.1.2 Infection control processes include prevention of the spread of communicable diseases.

33.8.1.3 Infection control processes include prevention of the spread of infection through use of testing and rehabilitation equipment.

33.9 Risk Management

33.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

33.9.1 Criteria

33.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of the organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

33.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

33.9.1.3 Security measures are in place and implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated.

Linked criterion:
7.4.1.4

33.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated in the department.

Linked criterion:
7.5.1.1

33.9.1.5 The organisation's policy on handling, storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 34 DIETETIC SERVICE

OVERVIEW OF THE DIETETIC SERVICE

A healthcare organisation'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, planning and delivery of care
- monitoring and evaluating the results of the care provided for each patient and
- adapting and implementing care plans according to the patients' changing needs.

A care plan is not sufficient to achieve optimal outcomes unless the delivery of services is co-ordinated and monitored. Therefore, a healthcare organisation needs to consider the care it provides as part of an integrated system of services. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. The organisation needs to ensure that scarce professional resources are used optimally, e.g. supervising/managing non-professional members of the health team and monitoring the care that they provide. Processes for continuity and coordination of care among the members of the multi-disciplinary/interdisciplinary team must be implemented in and between services and networking organisations.

This chapter is designed to enable the staff in the dietetic service to assess, monitor and improve the quality of care in their own service. The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation and needs to comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

Standards

34.1 Management of the Service

34.1.1 The dietetic service is managed to ensure the provision of a safe and effective service.

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performance requires clear leadership from a suitably qualified individual. The responsibilities of each staff member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement.

Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated. They also need to be authorised by the organisational leaders.

34.1.1 Criteria

34.1.1.1 A qualified dietician individual is responsible for the dietetic service.

This refers to a person appointed to the management position in terms of qualification and job specifications.

Where the position is filled by someone in an acting capacity this criterion will be scored PC.

Where there is no job specification this will be scored NC.

Linked criteria:
1.3.1.1, 1.2.7.2
2.2.1.1, 2.5.1.1

34.1.1.2 The dietetic service manager ensures that policies and procedures are available to guide the staff and that they are implemented.

Linked criteria:
1.2.6.1
34.3.1.1

34.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisational chart which reflects the persons required to provide an adequate service for the facility. However, where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criterion:
1.1.1.2
2.2.1.4

34.1.1.4 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement signed by the incumbent and the supervisor/manager must be available.

Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

34.1.1.5 The manager ensures that there is a documented welfare programme in place for the staff within the department.

34.2 Facilities and Equipment

34.2.1 The service has adequate facilities and serviceable equipment to meet the treatment needs of the population served.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure, that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

34.2.1 Criteria

34.2.1.1 There is adequate space for dieticians to treat patients effectively.

Root criterion for criteria 34.2.1.3 and 4

The requirements will vary according to the size of the facility, the number of dieticians and the services provided. There should be adequate waiting space for clients/patients, private interview rooms (one per dietician), administrative space and storage space for records and equipment. Sometimes this can be shared with the food services manager in the same facility.

Linked criteria:
1.2.2.2

34.2.1.2 Adequate and relevant equipment and consumables are available to provide an effective service.

The requirements will vary according to the size of the facility, the number of dieticians and the services provided.

Linked criterion:
1.2.2.3

34.2.1.3 There is adequate space for the storage of equipment and consumables.

34.2.1.4 Privacy is ensured through private cubicles, curtains or screens.

Critical criterion

Linked criteria:
1.2.5.1
5.2.1.1 and 2
6.1.2.1

34.3 Policies and Procedures

34.3.1 Policies and procedures guide the management and patient care in the department.

Standard Intent

As indicated in 34.1.1, departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department. It is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated. They also need to be authorized by the organisational leaders.

Clinical policies and procedures guide professional personnel in providing uniform care to patients. Clinical guidelines are frequently helpful and may be included in the care process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

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 and
- special qualifications or skills of the personnel involved in the care process.

Policies and procedures should focus on the following: e.g.

- consultation and referral systems
- special dietary requirements
- menu planning

- the provision of nutritional supplements.

34.3.1 Criteria

34.3.1.1 Policies and procedures that guide the personnel in the management and clinical aspects of the dietetic service are available and implemented.

Relevant, documented policies and procedures including the hospital generic policies should be available.

Collaboration of the dietetic service with other services in the formulation of policies should be sought, e.g. systems for referring patients from other departments to the dietetic service.

Policies specific to dietetics could include policies relating to the number of personnel required and their qualifications; professional development; peer reviews; hours during which the service is operational; referrals to outside organisations; keeping of statistics; assessment of patients; any interventions/procedures performed, etc.

Linked criterion:
34.1.1.2

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

34.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all staff members.

34.3.1.4 Each policy and procedure is reviewed as per organisational requirement.

34.4 Coordination of Patient Care

34.4.1 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 the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means according to appropriate policies determined by the organisation. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records and case management).

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team and is made available to all relevant caregivers who are authorised to have access to its content.

Establishing goal-orientated rehabilitation in a general hospital setting can be very difficult. One of the two models below may be used, or they may be combined:

1. Multidisciplinary 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 usually requires five sub-components:

- a unique patient-centred plan, formulated by the patient and the multidisciplinary team
- the establishment of achievable goals
- patient participation to reach those goals
- this should result in the person reaching his/her potential and
- outcomes need to be measured/demonstrated.

34.4.1 Criteria

34.4.1.1 There is a multidisciplinary/interdisciplinary approach to the development and implementation of a therapeutic programme.

Please note: this will never be NA because there will always be team members as indicated in criterion 34.4.1.2.

Linked criteria:
1.3.2.1
34.4.3.1

34.4.1.2 The team consists of appropriately qualified personnel, including representatives from the medical, nursing, social work, physiotherapy, dietetic service, occupational therapy, clinical psychology and other disciplines, departments or services as appropriate.

Linked criterion:
1.3.1.7

34.4.1.3 The team members' responsibilities include the development and implementation of a comprehensive, individualised care plan for each patient, based on the assessment of the patient.

This refers to the relevant forms/documents that need to be present in the patient's clinical record as well as the completeness of entries made. For this purpose the results ***of patient record audits*** *need to be taken into account.*

Linked criterion:
1.3.2.4

34.4.1.4 The team conducts periodic re-evaluation of each patient's care plan to determine whether established goals are being or have been met and whether change in the patient's condition requires modification of goals.

*This criterion is assessed by means of a **patient record audit.***

34.4.1.5 The team includes the patient and his/her family in the development and review of the care plan as appropriate.

Family meetings/discussions are of utmost importance and it is recommended that meetings/discussions are held on or shortly after admission during rehabilitation and prior to discharge.

*This criterion is assessed by means of a **patient record audit.***

34.4.1.6 The multidisciplinary/interdisciplinary team meets regularly to coordinate patient care.

*This criterion is assessed by means of a **patient record audit.***

34.4.2 All patients treated by dieticians 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 will be modified to meet the needs of each patient.

Regular reassessments of patients 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.

34.4.2 Criteria

34.4.2.1 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

*Compliance will be verified during the **patient record audit** which will focus on the legibility of signatures and the identification of designations/qualifications.*

Linked criterion:
2.5.1.1

34.4.2.2 The findings of assessments performed outside the organisation are verified on admission.

34.4.2.3 Patients are reassessed at intervals appropriate to their conditions, care plans, individual needs or according to organisational policies and procedures.

Critical criterion

Compliance will be verified during the ***patient record audit.***

- *Is there evidence of appropriate follow-up?*
- *Did the planned follow-up take place?*
- *Is the case closed or awaiting further action?*
- *Are interventions comprehensively documented?*

Linked criterion:
1.2.5.4
8.2.1.5

34.4.3 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 and standards of practice. Regardless of the source the scientific basis of guidelines should be reviewed and approved by organisational 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 organisational resources. Once implemented, guidelines are 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.

34.4.3 Criteria

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

The provision of clinical guidelines is especially important if there is more than one dietician and they have trained at different institutions. The aim is to ensure that assessments are planned to cover all relevant aspects and that the appropriate interventions take place. In the absence of guidelines this criterion will be scored NC.

This criterion requires evidence of the implementation of/adherence to these guidelines and such evidence is obtained from **the results of clinical audits.**

This will be scored PC by default if there are no structured clinical audits to monitor the implementation of the guidelines.

Linked criterion:
34.3.1.1

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

Clinical audits cannot be done on ALL guidelines but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done this criterion is scored NC.

Linked criterion:
8.2.1.4

34.4.3.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

34.5 Patient and Family Education

34.5.1 Education supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to participate and make decisions on how to continue with care at home.

Variables like educational literacy, beliefs and limitations are taken into account.
Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition when a patient or family directly participates in providing care they need to be educated.

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

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.
Community organisations that support health promotion and disease prevention education are identified and when possible on-going relationships are established.

The service has a range of health promotion information materials and resources, specific to the particular patient population. Health information provided is recorded to ensure follow-up and to reduce medico-legal risks.

*Evidence of compliance is obtained from patient interviews as well as **patient record audits***

34.5.1 Criteria

34.5.1.1 Patients and families indicate that they have been informed about participation in the care process.

Root criterion

Compliance will be verified during patient interviews.

Linked criteria:
4.2.3.2
5.3.1.2

34.5.1.2 Patients and families indicate that they have been informed about any financial implications of care decisions.

Compliance will be verified during patient interviews.

Linked criterion:
4.2.3.3

34.5.1.3 Patients indicate that they have been informed about relevant high health risks, e.g. the safe use of medication in relation to medicine/food interactions.

34.5.1.4 Interaction between personnel, the patient and the family is noted in the patient's record.

*Compliance will be verified during the **patient record audit.***

Linked criterion:
5.3.1.2

34.6 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/ 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:

a) patient assessment
b) the success of dietetic service procedures carried out
c) the availability, contents and use of patient records and
d) 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 and
- graphed and/or tabled results, as appropriate.

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

34.6.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit;*
- *participation in documentation (patient record) audit; and*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

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

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies. Measurable indicators must reflect processes related to the dietetics services. They should, therefore, focus on high-risk, high-volume or problem-prone conditions and measure both the processes and the outcomes of patient care.

Examples:

1. *management of patients with diabetes; hypertension; burns; cardiac disease etc.*
2. *case discussions;*
3. *specialised investigative studies;*
4. *reports on negative incidents, etc.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

34.6.1.4 A documentation audit system is in place.

Documented evidence of such patient record audits must be provided at departmental level. The score of this criterion needs to reflect the aggregated average score of all relevant criteria in this document.

Where the patient record audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

34.7 Patient Rights

34.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

34.7.1 Criteria

34.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

34.7.1.2 Measures are taken to protect the patient's privacy.

Linked criteria:
5.2.1.1-3
6.1.2.1

34.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

34.8 Prevention and Control of Infection

34.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

34.8.1 Criteria

34.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root criterion

The department participates in and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

34.8.1.2 Infection control processes include prevention of the spread of communicable diseases

34.8.1.3 Infection control processes include prevention of the spread of food-related infections.

34.8.1.4 Infection control processes include effective hand washing procedures.

34.9 Risk Management

34.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

34.9.1 Criteria

34.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of the organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

34.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated in the department. Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

34.9.1.3 Security measures are in place and implemented to ensure the safety of patients, staff and visitors.

The department's participation in the facility's overall security plan will be evaluated in the department.

Linked criterion:
7.4.1.4

34.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated in the department.

Linked criterion:
7.5.1.1

34.9.1.5 The organisation's policy on handling, storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 35 SPEECH THERAPY SERVICE

OVERVIEW OF THE SPEECH THERAPY SERVICE

A healthcare organisation'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, planning and delivery of care
- monitoring and evaluating the results of the care provided for each patient and
- adapting and implementing care plans according to the patients' changing needs.

A care plan is not sufficient to achieve optimal outcomes unless the delivery of services is co-ordinated and monitored. Therefore, a healthcare organisation needs to consider the care it provides as part of an integrated system of services. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. The organisation needs to ensure that scarce professional resources are used optimally, e.g. supervising/managing non-professional members of the health team and monitoring the care that they provide. Processes for continuity and coordination of care among the members of the multi-disciplinary/interdisciplinary team must be implemented in and between services and networking organisations.

This chapter is designed to enable the personnel in the speech therapy service to assess, monitor and improve the quality of care in their own service. The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and needs to comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

Standards

35.1 Management of the Service

35.1.1 The speech therapy service is managed to ensure the provision of a safe and effective service.

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each personnel member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement.

Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

35.1.1 Criteria

35.1.1.1 A designated individual is responsible for the speech therapy service.

This refers to a person appointed to the management position in terms of qualification and job specifications.

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

Where there is no job specification, this will be scored NC.

Linked criteria:
1.3.1.1, 1.2.7.2
2.2.1.1,2.5.1.1

35.1.1.2 The speech therapy service manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

The person who manages the service may be known by various titles such as head of unit or head of department.

Linked criteria:
1.2.6.1

35.3.1.1

35.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisational chart, which reflects the persons required to provide an adequate service for the facility. However where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criteria:
1.1.1.2
2.2.1.4

35.1.1.4 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.
Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

35.1.1.5 The manager ensures that there is a documented wellness programme in place for the staff within the department.

35.2 Facilities and Equipment

35.2.1 The service has adequate facilities and serviceable equipment to meet the treatment needs of the population served.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure, that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

35.2.1 Criteria

35.2.1.1 There is adequate space for speech therapists to treat patients effectively.

Root criterion for criteria 3 and 4

The requirements will vary according to the size of the facility, the number of speech therapists and the services provided. There should be adequate waiting space for clients/patients, private interview rooms, administrative space and storage space for records and equipment.
Linked criterion:
1.2.2.2

35.2.1.2 Adequate and relevant equipment and consumables are available to provide an effective service.

The requirements will vary according to the size of the facility, the number of speech therapists and the services provided. Equipment could include charts, therapy programmes and play kits, consumable and non-consumable materials for dysphagia, adaptive equipment etc.

Linked criterion:
1.2.2.3

35.2.1.3 There is adequate space for the storage of equipment and consumables.

35.2.1.4 Privacy is ensured through private cubicles, curtains or screens.

Critical criterion

Linked criteria:
1.2.5.1
5.2.1.1 and 2
6.1.2.1

35.3 Policies and Procedures

35.3.1 Policies and procedures guide the management and patient care in the department.

Standard Intent

As indicated in 35.1.1, departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

Clinical policies and procedures guide professional personnel in providing uniform care to patients. Clinical guidelines are frequently helpful and may be included in the process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

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 and
- special qualifications or skills of the personnel involved in the care process.

Policies and procedures should focus on patients and procedures, e.g.

- referral systems
- assessment methods
- treatment protocols
- high risk patients and procedures
- resuscitation techniques and procedures and
- treatment techniques and equipment.

35.3.1 Criteria

35.3.1.1 Policies and procedures that guide the personnel in the management and clinical aspects of the speech therapy service are implemented.

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the speech therapy service with other services in the formulation of policies should be sought, e.g. systems for referring patients from other departments to the speech therapy service.

Policies specific to the speech therapy service could include policies relating to the number of personnel required and their qualifications; professional development; peer reviews; hours during which the service is operational; referrals to outside organisations; keeping of statistics; assessment of patients; any interventions/procedures performed.

Linked criterion:
35.1.1.2

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

35.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel members.

35.3.1.4 Each policy and procedure is reviewed.

35.4 Coordination of Patient Care

35.4.1 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 the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means according to appropriate policies determined by the organisation. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers).

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team and is made available to all relevant caregivers who are authorised to have access to its content.

Establishing goal orientated rehabilitation in a general hospital setting can be very difficult. One of the two models below may be used, or they may be combined:

1. Multidisciplinary 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, 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 multidisciplinary team
- the establishment of achievable goals
- patient participation to reach those goals
- this should result in the person reaching his/her potential and
- outcomes need to be measured/demonstrated.

35.4.1 Criteria

35.4.1.1 There is a multidisciplinary/interdisciplinary approach to the development and implementation of a therapeutic programme.

Please note: this will never be NA, because there will always be team members as indicated in criterion 35.4.1.2.

Linked criterion:
1.3.2.1
35.4.3.1

35.4.1.2 The team consists of appropriately qualified personnel, including representatives from the medical, nursing, social work, physiotherapy, speech therapy, occupational therapy, clinical psychology and other disciplines, departments or services, as appropriate.

Linked criterion:
1.3.1.7

35.4.1.3 The team members' responsibilities include the development and implementation of a comprehensive, individualised care plan for each patient, based on the assessment of the patient.

*This refers to the relevant forms/documents that need to be present in the patient's clinical record, as well as the completeness of entries made. For this purpose, the results **of patient record audits** need to be taken into account.*

Linked criterion:
1.3.2.4

35.4.1.4 The team conducts periodic re-evaluation of each patient's care plan to determine whether established goals are being or have been met and whether change in the patient's condition requires modification of goals.

*This criterion is assessed by means of a **patient record audit.***

35.4.1.5 The team includes the patient and his/her family in the development and review of the care plan, as appropriate.

*Family meetings/discussions are of utmost importance and it is recommended that meetings/discussions are held on or shortly after admission, during rehabilitation and prior to discharge. This criterion is assessed by means of a **patient record audit.***

35.4.1.6 The multidisciplinary/interdisciplinary team meets regularly to coordinate patient care.

*This criterion is assessed by means of a **patient record audit.***

35.4.2 All patients treated by speech therapists 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 will be modified to meet the needs of each patient.

Regular reassessments of patients ensure that the continuing care plans are suited to the needs of the patients and are essential to justify the treatment plans and on-going care.

35.4.2 Criteria

35.4.2.1 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

*Compliance will be verified during the **patient record audit,** which will focus on the legibility of signatures and the identification of designations/qualifications*

Linked criterion:
2.5.1.1

35.4.2.2 The findings of assessments performed outside the organisation are verified on admission.

35.4.2.3 Patients are reassessed at intervals appropriate to their conditions, care plans, individual needs or according to organisational policies and procedures.

Critical criterion

*Compliance will be verified during the **patient record audit.***

- *Is there evidence of appropriate follow-up?*
- *Did the planned follow-up take place?*
- *Is the case closed or awaiting further action?*
- *Are interventions comprehensively documented?*

Linked criteria:
1.2.5.4
8.2.1.5

35.4.3 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 and standards of practice. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational 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 organisational resources. Once implemented, guidelines are 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.

35.4.3 Criteria

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

The provision of clinical guidelines is especially important if there is more than one speech therapist and they have trained at different institutions. The aim is to ensure that assessments are planned to cover all relevant aspects and that the appropriate interventions take place.

*This criterion requires evidence of the implementation of/adherence to these guidelines and such evidence is obtained from **the results of clinical audits.***

This will be scored PC by default if there are no structured clinical audits to monitor the implementation of the guidelines.

Linked criterion:
35.3.1.1

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

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Linked criterion:
8.2.1.4

35.4.3.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

35.5 Patient and Family Education

35.5.1 Education supports patient and family participation in care decisions and care processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Personnel collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care and continue care at home.
Variables like educational literacy, beliefs and limitations are taken into account.
Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care they need to be educated.

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

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

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

The service has a range of health promotion information materials and resources, specific to the particular patient population. Health information provided is recorded to ensure follow-up and to reduce medico-legal risks.

*Evidence of compliance is obtained from patient interviews as well as **patient record audits***

35.5.1 Criteria

35.5.1.1 Patients and families indicate that they have been informed about participation in the care process.

Root criterion

Compliance will be verified during patient interviews.

Linked criteria:
4.2.3.2
5.3.1.2

35.5.1.2 Patients and families indicate that they have been informed about any financial implications of care decisions.

Compliance will be verified during patient interviews.

Linked criterion:
4.2.3.3

35.5.1.3 Interaction between personnel, the patient and the family is noted in the patient's record.

*Compliance will be verified during the **patient record audit.***

35.6 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/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:

a) patient assessment
b) success of speech therapy procedures carried out
c) the availability, contents and use of patient records and
d) 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 and
- graphed and/or tabled results, as appropriate.

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

35.6 .1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit and*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

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

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits. These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies. Measurable indicators must reflect processes related to the speech therapy service. They should therefore focus on high-risk, high-volume or problem prone conditions and measure both the processes and the outcomes of patient care.

Examples:

1. *the treatment of swallowing disorders*
2. *cognitive impairment, dysarthria*
3. *asphasia*
4. *delayed developmental milestones*
5. *the implementation of clinical guidelines by means of structured clinical audits, etc.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

35.6.1.4 A documentation audit system is in place.

Documented evidence of such patient record audits must be provided at departmental level. The score of this criterion needs to reflect the aggregated average score of all relevant criteria in this document.

Where the patient record audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

35.7 Patient Rights

35.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

35.7.1 Criteria

35.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.
This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

35.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3

6.1.2.1

35.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

35.8 Prevention and Control of Infection

35.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

35.8.1 Criteria

35.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root Criterion

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

35.8.1.2 Infection control processes include prevention of the spread of communicable diseases

35.8.1.3 Infection control processes include prevention of the spread of infection through testing and rehabilitation equipment.

35.9 Risk Management

35.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes on (Service Element 7).

35.9.1 Criteria

35.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, personnel and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be include:

Linked criterion:
7.1.1.1

35.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated in the department.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

35.9.1.3 Security measures are in place and implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated.

Linked criterion:
7.4.1.4

35.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

35.9.1.5 The organisation's policy on handling, storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 36: CLINICAL PSYCHOLOGY SERVICE

OVERVIEW OF THE CLINICAL PSYCHOLOGY SERVICE

A healthcare organisation'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, 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 patients' changing needs.

A care plan is not sufficient to achieve optimal outcomes unless the delivery of services is co-ordinated and monitored. Therefore, a healthcare organisation needs to consider the care it provides as part of an integrated system of services. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. The organisation needs to ensure that scarce professional resources are used optimally, e.g. supervising/managing non-professional members of the health team and monitoring the care that they provide. Processes for continuity and coordination of care among the members of the multi-disciplinary/interdisciplinary team must be implemented in and between services and networking organisations.

This chapter is designed to enable the personnel in the clinical psychology service to assess, monitor and improve the quality of care in their own service. The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and needs to comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

Standards

36.1 Management of the Service

36.1.1 The clinical psychology service is managed to ensure the provision of a safe and effective service.

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performance requires clear leadership from a suitably qualified individual. The responsibilities of each staff member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement. Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

36.1.1 Criteria

36.1.1.1 A designated individual is responsible for the clinical psychology service.

This refers to a person appointed to the management position in terms of *qualification and job specifications.*

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

Where there is no job specification, this will be scored NC.

Linked criteria:
1.3.1.1, 1.2.7.2
2.2.1.1, 2.5.1.1

36.1.1.2 The clinical psychology service manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

Linked criteria:
1.2.6.1
36.3.1.1

36.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisational chart, which reflects the persons required to provide an adequate service for the facility. However where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criteria:
1.1.1.2
2.2.1.4

36.1.1.4 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.

Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

36.1.1.5 The manager ensures that there is a documented wellness programme in place for the staff within the department.

36.2 Facilities and Equipment

36.2.1 The service has adequate facilities and serviceable equipment to meet the treatment needs of the population served.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure, that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

36.2.1 Criteria

36.2.1.1 There is adequate space for clinical psychologists to treat patients effectively.

Root criterion for criteria 36.2.1.3 and 4

The requirements will vary according to the size of the facility, the number of clinical psychologists and the services provided. There should be adequate waiting space for clients/patients, private interview rooms, space for group and family therapy, administrative space and storage space for records and equipment.

Linked criterion:
1.2.2.2

36.2.1.2 Adequate and relevant equipment and consumables are available to provide an effective service.

Where children are involved, a room with appropriate equipment and toys, preferably with a one-way mirror for observation, should be available. Sometimes this facility can be shared with the social workers in the same hospital or other setting.

Linked criteria:
1.2.2.3

36.2.1.3 There is adequate space for the storage of equipment and consumables.

36.2.1.4 Privacy is ensured through private cubicles, curtains or screens.

Critical criterion

Linked criteria:
1.2.5.1
5.2.1.1 and 2
6.1.2.1

36.3 Policies and Procedures

36.3.1 Policies and procedures guide the management and patient care in the department.

Standard Intent

As indicated in 36.1.1, departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

Clinical policies and procedures guide professional personnel in providing uniform care to patients. Clinical guidelines are frequently helpful and may be included in the process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

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 and
- special qualifications or skills of the personnel involved in the care process

Policies and procedures should focus on patients and procedures, e.g.

- referral systems
- assessment of patients

- treatment protocols
- testing and treatment techniques
- high risk patients and procedures and
- the confidentiality of patient information.

36.3.1 Criteria

36.3.1.1 Policies and procedures that guide the personnel in the management and clinical aspects of the clinical psychology service are implemented.

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the clinical psychology service with other services in the formulation of policies should be sought, e.g. systems for referring patients from other departments to the psychology service.

Policies specific to the psychology service could include policies relating to the number of personnel required and their qualifications; professional development; peer reviews; hours during which the service is operational; referrals to outside organisations; keeping of statistics; assessment of patients; any interventions/procedures performed, etc.

Linked criterion:
36.1.1.2

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

36.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all staff members.

36.3.1.4 Each policy and procedure is reviewed as per organisational requirement.

36.4 Coordination of Patient Care

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

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team and is made available to all relevant caregivers who are authorised to have access to its content.

Establishing goal-orientated rehabilitation in a general hospital setting can be very difficult. One of the two models below may be used, or they may be combined:

1. Multidisciplinary 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, 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 multidisciplinary team;
- the establishment of achievable goals
- patient participation to reach those goals
- this should result in the person reaching his/her potential and
- outcomes need to be measured/demonstrated.

36.4.1 Criteria

36.4.1.1 There is a multidisciplinary/interdisciplinary approach to the development and implementation of a therapeutic programme.

Please note: this will never be NA, because there will always be team members as indicated in criterion 36.4.1.2.

Linked criteria:
1.3.2.1
36.4.3.1

36.4.1.2 The team consists of appropriately qualified personnel, including representatives from the medical, nursing, social work, clinical psychology, occupational therapy, clinical psychology and other disciplines, departments or services, as appropriate.

Linked criterion:
1.3.1.7

36.4.1.3 The team members' responsibilities include the development and implementation of a comprehensive, individualised care plan for each patient, based on the assessment of the patient.

*This refers to the relevant forms/documents that need to be present in the patient's clinical record, as well as the completeness of entries made. For this purpose, the results **of patient record audits** need to be taken into account.*

Linked criterion:
1.3.2.4

36.4.1.4 The team conducts periodic re-evaluation of each patient's care plan to determine whether established goals are being or have been met and whether change in the patient's condition requires modification of goals.

*This criterion is assessed by means of a **patient record audit.***

36.4.1.5 The team includes the patient and his/her family in the development and review of the care plan, as appropriate.

*Family meetings/discussions are of utmost importance and it is recommended that meetings/discussions are held on or shortly after admission, during rehabilitation and prior to discharge. This criterion is assessed by means of a **patient record audit.***

36.4.1.6 The multidisciplinary/interdisciplinary team meets regularly to co-ordinate patient care.

*This criterion is assessed by means of a **patient record audit.***

36.4.2 All patients treated by clinical psychologists 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 will be modified to meet the needs of each patient.

Regular reassessments of patients ensure that the continuing care plans are suited to the needs of the patients and are essential to justify the treatment plans and on-going care.

36.4.2 Criteria

36.4.2.1 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

*Compliance will be verified during the **patient record audit,** which will focus on the legibility of signatures and the identification of designations/qualifications.*

Linked criterion:
2.5.1.1

36.4.2.2 The findings of assessments performed outside the organisation are verified on admission.

36.4.2.3 Patients are reassessed at intervals appropriate to their conditions, care plans, individual needs or according to organisational policies and procedures.

Critical criterion

*Compliance will be verified during the **patient record audit.***

- *Is there evidence of appropriate follow-up?*
- *Did the planned follow-up take place?*
- *Is the case closed or awaiting further action?*
- *Are interventions comprehensively documented?*

Linked criteria:
1.2.5.4
8.2.1.5

36.4.3 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, and standards of practice. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational 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 organisational resources. Once implemented, guidelines are 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.

36.4.3 Criteria

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

The provision of guidelines is especially important if there is more than one clinical psychologist and they have trained at different institutions. The aim is to ensure that assessments are planned to cover all relevant aspects and that the appropriate interventions take place.

*This criterion requires evidence of the implementation of/adherence to these guidelines and such evidence is obtained from **the results of clinical audits.***

This will be scored PC by default if there are no structured clinical audits to monitor the implementation of the guidelines.

Linked criterion:
36.3.1.1

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

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Linked criterion:
8.2.1.4

36.4.3.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

36.5 Patient and Family Education

36.5.1 Education supports patient and family participation in care decisions and care processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to paricipate and make care decisionson how to continue with care at home.

Variables like educational literacy, beliefs and limitations are taken into account. Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care they need to be educated.

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

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

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

The service has a range of health promotion information materials and resources, specific to the particular patient population. Health information provided is recorded to ensure follow-up and to reduce medico-legal risks.

Evidence of compliance is obtained from patient interviews as well as ***patient record audits***

36.5.1 Criteria

36.5.1.1 Patients and families indicate that they have been informed about participation in the care process.

Root criterion

Compliance will be verified during patient interviews.

Linked criteria:
4.2.3.2
5.3.1.2

36.5.1.2 Patients and families indicate that they have been informed about any financial implications of care decisions.

Compliance will be verified during patient interviews.

Linked criterion:
4.2.3.3

36.5.1.3 Interaction between personnel, the patient and the family is noted in the patient's record.

Compliance will be verified during the ***patient record audit.***

36.6 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/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:

a) patient assessment
b) the success of clinical psychology procedures carried out
c) the availability, contents and use of patient records and
d) 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 and
- graphed and/or tabled results, as appropriate.

A once-off project, e.g. acquiring equipment for play therapy, will be scored NC.

36.6.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit;*
- *participation in documentation (patient record) audit; and*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

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

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies. Measurable indicators must reflect processes related to the clinical psychology service. They should, therefore, focus on high-risk, high-volume or problem-prone conditions and measure both the processes and the outcomes of patient care.

Examples:

1. *the time frame to complete the assessments*
2. *monitoring contracted outcome-based therapy time*
3. *re-admissions to the service, i.e. revolving door syndrome*
4. *implementation of clinical guidelines by means of structured clinical audits, etc.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

36.6.1.4 A documentation audit system is in place.

Documented evidence of such patient record audits must be provided at departmental level. The score of this criterion needs to reflect the aggregated average score of all relevant criteria in this document.

Where the patient record audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

36.7 Patient Rights

36.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

36.7.1 Criteria

36.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

36.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

36.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

36.8 Prevention and Control of Infection

36.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

36.8.1 Criteria

36.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root Criterion

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

36.8.1.2 Infection control processes includes prevention of the spread of infection related to testing and rehabilitation equipment.

36.9 Risk Management

36.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

36.9.1 Criteria

36.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of the organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

36.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

36.9.1.3 Security measures are in place and implemented to ensure the safety of patients, staff and visitors.

The department's participation in the facility's overall security plan will be evaluated.

Linked criterion:
7.4.1.4

36.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

36.9.1.5 The organisation's policy on handling, storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.5.1.1

SE 37 SOCIAL WORK SERVICE

OVERVIEW OF SOCIAL WORK SERVICE

A healthcare organisation'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, planning and delivery of care
- monitoring and evaluating the results of the care provided for each patient and
- adapting and implementing care plans according to the patients' changing needs.

A care plan is not sufficient to achieve optimal outcomes unless the delivery of services is co-ordinated and monitored. Therefore, a healthcare organisation needs to consider the care it provides as part of an integrated system of services. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. The organisation needs to ensure that scarce professional resources are used optimally, e.g. supervising/managing non-professional members of the health team and monitoring the care that they provide. Processes for continuity and coordination of care among the members of the multi-disciplinary/interdisciplinary team must be implemented in and between services and networking organisations.

This chapter is designed to enable the personnel in the social work service to assess, monitor and improve the quality of care in their own service. The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and needs to comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

Standards

37.1 Management of the Service

37.1.1 The social work service is managed to ensure the provision of a safe and effective service.

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each staff member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement. Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

37.1.1 Criteria

37.1.1.1 A designated individual is responsible for the social work service.

This refers to a person appointed to the management position in terms of qualification and job specifications.

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

Where there is no job specification, this will be scored NC.

Linked criteria:
1.3.1.1, 1.2.7.2
2.2.1.1, 2.5.1.1

37.1.1.2 The social work service manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

Linked criteria:
1.2.6.1
37.3.1.1

37.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisational chart, which reflects the persons required to provide an adequate service for the facility. However, where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criteria:
1.1.1.2
2.2.1.4

37.1.1.4 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.

Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

37.1.1.5 The manager ensures that there is a documented wellness programme in place for the staff within the department.

37.2 Facilities and Equipment

37.2.1 The service has adequate facilities and serviceable equipment to meet the treatment needs of the population served.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

37.2.1 Criteria

37.2.1.1 There is adequate space for social workers to treat patients effectively.

Root criterion for criteria 37.2.1.3 and 37.2.1.4

The requirements will vary according to the size of the facility, the number of social workers and the services provided. There should be adequate waiting space for clients/patients, private interview rooms (one per social worker), administrative space and storage space for records and equipment.

Linked criterion:
1.2.2.2

37.2.1.2 Adequate and relevant equipment and consumables are available to provide an effective service.

Where children are involved, a room with appropriate equipment and toys, preferably with a one-way mirror for observation, should be available. This room may be shared with other services in the same facility.

Linked criterion:
1.2.2.3

37.2.1.3 There is adequate space for the storage of equipment and consumables.

37.2.1.4 Privacy is ensured through private, soundproof rooms.

Critical criterion

Linked criteria:
1.2.5.1
5.2.1.1 and 2
6.1.2.1

37.3 Policies and Procedures

37.3.1 Policies and procedures guide the management and patient care in the department.

Standard Intent

As indicated in 37.1.1, departmental policies and procedures are essential to give personnel the guidance they require to carry out the functions of the department. It is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need to be the authorzed by the organisational leaders.

Clinical policies and procedures guide professional personnel in providing uniform care to patients. Clinical guidelines are frequently helpful and may be included in the process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

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.

Policies and procedures should focus on the following:

- referral systems
- patient assessment
- liaison with relevant role-players and
- the confidentiality of patient information.

37.3.1 Criteria

37.3.1.1 Policies and procedures that guide the personnel in the management and clinical aspects of the social work service are implemented.

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the physiotherapy service with other services in the formulation of policies should be sought, e.g. systems for referring patients from other departments to the social work service.

Policies specific to the social work service could include policies relating to the number of personnel required and their qualifications; professional development; peer reviews; hours during which the service is operational; referrals to outside organisations; keeping of statistics; assessment of patients; any interventions/procedures performed, etc.

Linked criterion:
37.1.1.2

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

37.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all staff members.

37.3.1.4 Each policy and procedure is reviewed.

37.4 Coordination of Patient Care

37.4.1 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 the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means according to appropriate policies determined by the organisation. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers).

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team and is made available to all relevant caregivers who are authorised to have access to its content.

Establishing goal-orientated rehabilitation in a general hospital setting can be very difficult. One of the two models below may be used, or they may be combined:

1. Multidisciplinary 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, 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
- this should result in the person reaching his/her potential and
- outcomes need to be measured/demonstrated.

37.4.1 Criteria

37.4.1.1 There is a multidisciplinary/interdisciplinary approach to the development and implementation of a therapeutic programme.

Please note: this will never be NA, because there will always be team members as indicated in criterion 37.4.1.2.

Linked criteria:
1.3.2.1
37.4.3.1

37.4.1.2 The team consists of appropriately qualified personnel, including representatives from the medical, nursing, social work, physiotherapy, occupational therapy, clinical psychology and other disciplines, departments or services, as appropriate.

Linked criterion:
1.3.1.7

37.4.1.3 The team members' responsibilities include the development and implementation of a comprehensive, individualised care plan for each patient, based on the assessment of the patient.

This refers to the relevant forms/documents that need to be present in the patient's clinical record, as well as the completeness of entries made. For this purpose, the results ***of patient record audits*** *need to be taken into account.*

Linked criterion:
1.3.2.4

37.4.1.4 The team conducts periodic re-evaluation of each patient's care plan to determine whether established goals are being or have been met and whether change in the patient's condition requires modification of goals.

*This criterion is assessed by means of a **patient record audit.***

37.4.1.5 The team includes the patient and his/her family in the development and review of the care plan, as appropriate.

*Family meetings/discussions are of utmost importance and it is recommended that meetings/discussions are held on or shortly after admission, during rehabilitation and prior to discharge. This criterion is assessed by means of a **patient record audit.***

37.4.1.6 The multidisciplinary/interdisciplinary team meets regularly to coordinate patient care.

*This criterion is assessed by means of a **patient record audit.***

37.4.2 All patients treated by social workers 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 will be modified to meet the needs of each patient.

Regular reassessments of patients ensure that the continuing care plans are suited to the needs of the patients and are essential to justify the treatment plans and on-going care.

37.4.2 Criteria

37.4.2.1 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

*Compliance will be verified during the **patient record audit,** which will focus on the legibility of signatures and the identification of designations/qualifications*

Linked criterion:
2.5.1.1

37.4.2.2 The findings of assessments performed outside the organisation are verified on admission.

37.4.2.3 Patients are reassessed at intervals appropriate to their conditions, care plans, individual needs or according to organisational policies and procedures.

Critical criterion

Compliance will be verified during the ***patient record audit.***

- *Is there evidence of appropriate follow-up?*
- *Did the planned follow-up take place?*
- *Is the case closed or awaiting further action?*
- *Are interventions comprehensively documented?*

Linked criteria:
1.2.5.4
8.2.1.5

37.4.3 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, and standards of practice. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational 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 organisational resources. Once implemented, guidelines are 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.

37.4.3 Criteria

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

The provision of guidelines is especially important if there is more than one social worker and they have trained at different institutions. The aim is to ensure that assessments are planned to cover all relevant aspects and that the appropriate interventions take place.

This criterion requires evidence of the implementation of/adherence to these guidelines and such evidence is obtained from ***patient record audits*** *and clinical audits.*

This will be scored PC by default if there are no structured clinical audits to monitor the implementation of the guidelines.

Linked criterion:
37.4.1.1

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

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Linked criterion:
8.2.1.4

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

Linked criterion:
1.3.2.2

37.5 Patient and Family Education

37.5.1 Education supports patient and family participation in care decisions and processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Staff collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care and continue care at home.
Variables like educational literacy, beliefs and limitations are taken into account.
Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record.

Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care, for example, changing dressings, feeding and administration, they need to be educated.

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

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance, instructions in the safe and effective use of medications and medical equipment.
Community organisations that support health promotion and disease prevention education are identified and, when possible, on-going relationships are established.

The service has a range of health promotion information materials and resources, specific to the particular patient population. Health information provided is recorded to ensure follow-up and to reduce medico-legal risks.

*Evidence of compliance is obtained from patient interviews as well as **patient record audits***

37.5.1 Criteria

37.5.1.1 Patients and families indicate that they have been informed about participation in the care process.

Root criterion

Compliance will be verified during patient interviews.

Linked criteria:
4.2.3.2
5.3.1.2

37.5.1.2 Patients and families indicate that they have been informed about any financial implications of care decisions.

Compliance will be verified during patient interviews.

Linked criterion:
4.2.3.3

37.5.1.3 Interaction between personnel, the patient and the family is noted in the patient's record.

*Compliance will be verified during the **patient record audit.***

37.6 Quality Improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/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:

a) patient assessment
b) the success of social work procedures carried out

c) the availability, contents and use of patient records
d) 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 and
- graphed and/or tabled results, as appropriate.

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

37.6.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit and*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

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

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings, or specialised investigative studies. Measurable indicators must reflect processes related to the social work service. They should, therefore, focus on high-risk, high-volume or problem prone conditions and measure both the processes and the outcomes of patient care.

Examples:

1. *the management of patient presenting with stroke, spinal cord injury, burns..*
2. *the implementation of clinical guidelines by means of structured clinical audits.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

37.6.1.4 A documentation audit system is in place.

Documented evidence of such patient record audits must be provided at departmental level. The score of this criterion needs to reflect the aggregated average score of all relevant criteria in this document.

Where the patient record audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

37.7 Patient Rights

37.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

37.7.1 Criteria

37.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable. Implementation of policies will be evaluated during the patient record audits and patient interviews as well as by observation.

This applies to all the relevant criteria below.
If the patient is a minor, appropriate channels are followed to safeguard the child's right to access health services.

Linked criterion:
5.1.1.3

37.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Clients are accorded the privacy they deserve by securing a secluded place (e.g. in hospital wards) for counselling.

Linked criteria:
5.2.1.1-3
6.1.2.1

37.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

37.8 Prevention and Control of Infection

37.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

37.8.1 Criteria

37.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root criterion

The department participates in, and has documented evidence of, the identification of risks in the department. Such documentation must form part of the organisation-wide infection control processes.

When handling cases in medical wards and TB Isolation Clinic, appropriate masks are utilised and are stored as per the recommendations of the infection control department.

Linked criteria:
9.2.1.1

37.8.1.2 Infection control processes include prevention of the spread of communicable diseases

37.8.1.3 Infection control processes includes prevention of the spread of infection related to equipment.

37.9 Risk Management

37.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes (Service Element 7).

37.9.1 Criteria

37.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of the organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, staff and visitor-related risks, financial and legal risks, physical facility, security and environmental risks should be included.

Linked criterion:
7.1.1.1

37.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse (sentinel) events is available and includes the documentation of interventions and responses to recorded incidents.

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

37.9.1.3 Security measures are in place and implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated.

Linked criterion:
7.4.1.4

37.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated in the department.

Linked criterion:
7.5.1.1

37.9.1.5 The organisation's policy on handling, storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1

SE 38 AUDIOLOGY SERVICE

OVERVIEW OF THE AUDIOLOGY SERVICE

A healthcare organisation'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, planning and delivery of care
- monitoring and evaluating the results of the care provided for each patient and
- adapting and implementing care plans according to the patients' changing needs.

A care plan is not sufficient to achieve optimal outcomes unless the delivery of services is co-ordinated and monitored. Therefore, a healthcare organisation needs to consider the care it provides as part of an integrated system of services. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. The organisation needs to ensure that scarce professional resources are used optimally, e.g. supervising/managing non-professional members of the health team and monitoring the care that they provide. Processes for continuity and coordination of care among the members of the multi-disciplinary/interdisciplinary team must be implemented in and between services and networking organisations.

This chapter is designed to enable the personnel in the audiology service to assess, monitor and improve the quality of care in their own service. The manager of the service works with other organisational leaders and managers to improve the quality of care throughout the organisation, and needs to comply with criteria relating to management, leadership, human resource development, infection control, environmental safety and quality improvement.

Standards

38.1 Management of the Service

38.1.1 The audiology service is managed to ensure the provision of a safe and effective service.

Standard Intent

Departmental and service managers are primarily responsible for ensuring that the mission of the organisation is met through the provision of management and leadership at departmental level. Good departmental or service performances require clear leadership from a suitably qualified individual. The responsibilities of each personnel member in the department are defined in writing; each one signs their own document to show that they are in agreement with their job description/performance agreement.

Documents prepared by each department define its goals, as well as identifying current and planned services. Lines of communication within each department are documented to ensure clear accountability.

Departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

38.1.1 Criteria

38.1.1.1 A designated individual is responsible for the audiology service.

This refers to a person appointed to the management position in terms of qualification and job specifications.

Where the position is filled by someone in an acting capacity, this criterion will be scored PC.

Where there is no job specification, this will be scored NC.

Linked criteria:
1.3.1.1, 1.2.7.2
2.2.1.1,2.5.1.1

38.1.1.2 The audiology service manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

Linked criteria:
1.2.6.1
38.3.1.1

38.1.1.3 The manager plans and implements an effective organisational structure to support his/her responsibilities and authority.

This criterion requires the availability of an organisational chart, which reflects the persons required to provide an adequate service for the facility. However where there are a number of vacant posts this criterion can only be marked PC. The organisation chart is a graphic representation of responsibility, relationships and formal lines of communication within the service.

Linked criteria:
1.1.1.2
2.2.1.4

38.1.1.4 The responsibilities of the manager are defined in writing.

A current job description/performance management agreement, signed by the incumbent and the supervisor/manager, must be available.

Key performance areas must be clearly stated.

Linked criteria:
1.3.1.2
2.3.1.1

38.1.1.5 The manager ensures that there is a documented wellness programme in place for staff within the department.

38.2 Facilities and Equipment

38.2.1 The service has adequate facilities and equipment to meet the treatment needs of the population served.

Standard Intent

Departmental managers need to work closely with organisational managers to ensure, that facilities and equipment are adequate. Departmental managers keep organisational managers informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

38.2.1 Criteria

38.2.1.1 There is adequate space for audiologists to treat patients effectively.

Root criterion for criteria 3 and 4

The requirements will vary according to the size of the facility, the number of audiologists and the services provided. There should be adequate waiting space for clients/patients, private interview rooms, administrative space and storage space for records and equipment.
Linked criterion:
1.2.2.2

38.2.1.2 Adequate and relevant equipment and consumables are available to provide an effective service.

The requirements will vary according to the size of the facility, the number of audiologists and the services provided. Equipment could include charts, therapy programmes and kits, articulation software, recording equipment etc.
Linked criterion:
1.2.2.3

38.2.1.3 There is adequate space for the storage of equipment and consumables.

38.2.1.4 Privacy is ensured through private cubicles, curtains or screens.

Critical criterion

Linked criteria:
1.2.5.1
5.2.1.1 and 2
6.1.2.1

38.3 Policies and Procedures

38.3.1 Policies and procedures guide the management and patient care in the department.

Standard Intent

As indicated in 38.1.1, departmental policies and procedures are essential. They give the personnel the guidance they require to carry out the functions of the department and it is important that there is a system for making sure that departmental policies and procedures are known, understood and implemented. Policies may be standardised for similar departments or be unique to the particular department. They need to be available, indexed, signed and dated; they also need the authority of the organisational leaders.

Clinical policies and procedures guide professional personnel in providing uniform care to patients. Clinical guidelines are frequently helpful and may be included in the process. Monitoring provides the information needed to ensure that the policies and procedures are adequately implemented and followed for all relevant patients and services.

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 and
- special qualifications or skills of the personnel involved in the care process.

Policies and procedures should focus on patients and procedures.

- referral systems
- assessment methods

- treatment protocols
- sedation and monitoring processes and
- treatment techniques and equipment.

38.3.1 Criteria

38.3.1.1 Policies and procedures that guide the personnel in the management and clinical aspects of the audiology service are implemented.

Relevant, documented policies and procedures, including the hospital generic policies, should be available.

Collaboration of the audiology service with other services in the formulation of policies should be sought, e.g. systems for referring patients from other departments to the audiology service.

Policies specific to the audiology service could include policies relating to the number of personnel required and their qualifications; professional development; peer reviews; hours during which the service is operational; referrals to outside organisations; keeping of statistics; assessment of patients; any interventions/procedures performed, etc.

Linked criterion:
38.1.1.2

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

38.3.1.3 Policies and procedures are compiled into a comprehensive manual, which is indexed and easily accessible to all personnel members.

38.3.1.4 Each policy and procedure is reviewed.

38.4 Coordination of Patient Care

38.4.1 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 the members of the multidisciplinary/interdisciplinary team. This can be through verbal, written or electronic means according to appropriate policies determined by the organisation. Clinical leaders should use techniques to better integrate and co-ordinate care for their patients (for example, team-delivered care, multi-departmental patient care rounds, combined care planning forums, integrated patient records, case managers).

The patient, family and others are included in the decision process when appropriate.

The patient's record contains a history of all care provided by the multidisciplinary/interdisciplinary team and is made available to all relevant

caregivers who are authorised to have access to its content.

Establishing goal-orientated rehabilitation in a general hospital setting can be very difficult. One of the two models below may be used, or they may be combined:

1. Multidisciplinary 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, 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 multidisciplinary team
- the establishment of achievable goals
- patient participation to reach those goals
- this should result in the person reaching his/her potential and
- outcomes need to be measured/demonstrated.

38.4.1 Criteria

38.4.1.1 There is a multidisciplinary/interdisciplinary approach to the development and implementation of a therapeutic programme.

Please note: this will never be NA, because there will always be team members as indicated in criterion 38.4.1.2.

Linked criterion:
1.3.2.1
38.4.3.1

38.4.1.2 The team consists of appropriately qualified personnel, including representatives from the medical, nursing, social work, physiotherapy, audiology, occupational therapy, clinical psychology and other disciplines, departments or services, as appropriate.

Linked criterion:
1.3.1.7

38.4.1.3 The team members' responsibilities include the development and implementation of a comprehensive, individualised care plan for each patient, based on the assessment of the patient.

This refers to the relevant forms/documents that need to be present in the patient's clinical record, as well as the completeness of entries made. For this purpose, the results ***of patient record audits*** *need to be taken into account.*

Linked criterion:
1.3.2.4

38.4.1.4 The team conducts periodic re-evaluation of each patient's care plan to determine whether established goals are being or have been met and whether change in the patient's condition requires modification of goals.

*This criterion is assessed by means of a **patient record audit.***

38.4.1.5 The team includes the patient and his/her family in the development and review of the care plan, as appropriate.

*Family meetings/discussions are of utmost importance and it is recommended that meetings/discussions are held on or shortly after admission, during rehabilitation and prior to discharge. This criterion is assessed by means of a **patient record audit.***

38.4.1.6 The multidisciplinary/interdisciplinary team meets regularly to co-ordinate patient care.

*This criterion is assessed by means of a **patient record audit.***

38.4.2 All patients treated by audiologists 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 will be modified to meet the needs of each patient.

Regular reassessments of patients ensure that the continuing care plans are suited to the needs of the patients and are essential to justify the treatment plans and on-going care.

38.4.2 Criteria

38.4.2.1 Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

*Compliance will be verified during the **patient record audit,** which will focus on the legibility of signatures and the identification of designations/qualifications*

Linked criterion:
2.5.1.1

38.4.2.2 The findings of assessments performed outside the organisation are verified on admission.

38.4.2.3 Patients are reassessed at intervals appropriate to their conditions, care plans, individual needs or according to organisational policies and procedures.

Critical criterion

Compliance will be verified during the ***patient record audit.***

- *Is there evidence of appropriate follow-up?*
- *Did the planned follow-up take place?*
- *Is the case closed or awaiting further action?*
- *Are interventions comprehensively documented?*

Linked criteria:
1.2.5.4
8.2.1.5

38.4.3 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 and standards of practice. Regardless of the source, the scientific basis of guidelines should be reviewed and approved by organisational 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 organisational resources. Once implemented, guidelines are 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.

38.4.3 Criteria

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

The provision of clinical guidelines is especially important if there is more than one audiologist and they have trained at different institutions. The aim is to ensure that assessments are planned to cover all relevant aspects and that the appropriate interventions take place.

This criterion requires evidence of the implementation of/adherence to these guidelines and such evidence is obtained from ***the results of clinical audits.***

This will be scored PC by default if there are no structured clinical audits to monitor the implementation of the guidelines.

Linked criterion:
38.3.1.1

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

Clinical audits cannot be done on ALL guidelines, but evidence must be available to show that the management of high cost, high risk, high volume and problem-prone conditions is considered for auditing.

If guidelines are available but structured clinical audits are not done, this criterion is scored NC.

Linked criterion:
8.2.1.4

38.4.3.3 Guidelines are reviewed and adapted on a regular basis.

Linked criterion:
1.3.2.2

38.5 Patient and Family Education

38.5.1 Education supports patient and family participation in care decisions and care processes.

Standard Intent

Learning occurs when attention is paid to the methods used to educate patients and families. The organisation selects appropriate educational methods and people to provide the education.

Personnel collaboration helps to ensure that the information patients and families receive is comprehensive, consistent and as effective as possible.

Education is focused on the specific knowledge and skills that the patient and his or her family will need to make care decisions, participate in care and continue care at home.
Variables like educational literacy, beliefs and limitations are taken into account.
Each organisation decides the placement and format for educational assessment, planning and delivery of information in the patient's record. Education is provided to support care decisions of patients and families. In addition, when a patient or family directly participates in providing care they need to be educated.

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

Education in areas that carry high risk to patients is routinely provided by the organisation, for instance instruction in the safe and effective use of medications and medical equipment.
Community organisations that support health promotion and disease prevention education are identified and, when possible, on-going relationships are established.

The service has a range of health promotion information materials and resources, specific to the particular patient population. Health information provided is recorded to ensure follow-up and to reduce medico-legal risks.

*Evidence of compliance is obtained from patient interviews as well as **patient record audits***

38.5.1 Criteria

38.5.1.1 Patients and families indicate that they have been informed about participation in the care process.

Root criterion

Compliance will be verified during patient interviews.

Linked criteria:
4.2.3.2
5.3.1.2

38.5.1.2 Patients and families indicate that they have been informed about any financial implications of care decisions.

Compliance will be verified during patient interviews.

Linked criterion:
4.2.3.3

38.5.1.3 Interaction between personnel, the patient and the family is noted in the patient's record.

*Compliance will be verified during the **patient record audit.***

38.6 Quality improvement

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

Standard Intent

This refers to the implementation of organisational quality improvement processes (Service Element 8).

It is the responsibility of management of the organisation to ensure that standards are set throughout the organisation. 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 organisation's central/management/coordinating quality management structures or systems. Departmental managers use available data and information to identify priority areas for quality monitoring and improvement.

*Compliance will be verified during the **patient record audit.***

Quality monitoring could include:

a) patient assessment
b) success of audiology procedures carried out
c) the availability, contents and use of patient records and

d) 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 and
- graphed and/or tabled results, as appropriate.

A once-off project such as acquiring a specific item of equipment will be scored NC. Single projects 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.

38.6.1 Criteria

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

The minimum requirement for considering compliance will be the availability of evidence of:

- *at least one clinical audit*
- *participation in documentation (patient record) audit and*
- *participation in monitoring near misses, sentinel and adverse events.*

Linked criterion:
8.2.2.1

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

As the emphasis is on the quality of patient care, this cannot be compliant if there is no evidence of clinical audits.

These could take the form of evaluation of the implementation of clinical guidelines, case discussions, morbidity/mortality meetings or specialised investigative studies. Measurable indicators must reflect processes related to the audiology service. They should therefore focus on high-risk, high-volume or problem-prone conditions and measure both the processes and the outcomes of patient care.

Examples:

6. *management of hearing loss*
7. *neo-natal screening*
8. *balance disorder management*
9. *dysphasia*
10. *the implementation of clinical guidelines by means of structured clinical audit.*

The information gained from the examples above must be used to identify and implement improvement programmes. Statistical reports without documented evidence of continuous quality improvement will be scored PC.

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

38.6.1.4 A documentation audit system is in place.

Documented evidence of such patient record audits must be provided at departmental level. The score of this criterion needs to reflect the aggregated average score of all relevant criteria in this document.

Where the patient record audit is a hospital-wide multidisciplinary process, which includes all clinical departments, this criterion will be scored according to the findings of the involvement of each department in the process.

Evaluation of results and remedial action taken must be documented.

Linked criterion:
8.2.1.5

38.7 Patient Rights

38.7.1 The department/service implements processes that support patient and family rights during care.

Standard Intent

This refers to the implementation of organisational policies on patient and family rights (Service Element 5).

Compliance will be verified during observation of patient care processes, patient record audits and patient interviews.

38.7.1 Criteria

38.7.1.1 There are processes that support patient and family rights during care.

The facility's policies will be evaluated against national legislation, where applicable.

Implementation of the policies will be evaluated during the patient record audits and patient interviews as well as by observation.

This applies to all the relevant criteria below.

Linked criterion:
5.1.1.3

38.7.1.2 Measures are taken to protect the patient's privacy, person and possessions.

Linked criteria:
5.2.1.1-3
6.1.2.1

38.7.1.3 The personnel respect the rights of patients and families to treatment and to refuse treatment.

Linked criterion:
5.4.1.1

38.8 Prevention and Control of Infection

38.8.1 The department/service implements infection prevention and control processes.

Standard Intent

This refers to the implementation of organisational processes for infection prevention and control (Service Element 9).

38.8.1 Criteria

38.8.1.1 The department identifies the procedures and processes associated with the risk of infection and implements strategies to reduce risk.

Root Criterion

The department participates in, and has documented evidence of, the identification of risks in their department. Such documentation must form part of the organisation-wide infection control processes.

Linked criterion:
9.2.1.1

38.8.1.2 Infection control processes include prevention of the spread of communicable diseases.

38.8.1.3 Infection control processes include prevention of the spread of infection through testing and rehabilitation equipment.

38.9 Risk Management

38.9.1 The department/service implements risk management processes.

Standard Intent

This refers to the implementation of organisational risk management processes on (Service Element 7).

38.9.1 Criteria

38.9.1.1 The department conducts on-going monitoring of risks through documented assessments as part of organisational risk management processes.

The department participates in and has documented evidence of the identification of risks in the department. Such documentation must form part of the organisation-wide risk management processes. All relevant aspects and services of the department, e.g. patient, personnel and visitor-related risks, financial and legal risks, physical facility, security and environmental risks, etc. should be included.

Linked criterion:
7.1.1.1

38.9.1.2 A system for monitoring incidents/near misses/sentinel/adverse events is available and includes the documentation of interventions and responses to recorded incidents.

Participation, at department level, in the facility's overall system for monitoring negative incidents/near misses/adverse events will be evaluated in the department.

Analysed data, with responses/remedial action related to departmental incidents is required.

Linked criteria:
7.1.1.7, 7.2.6.4

38.9.1.3 Security measures are in place and implemented to ensure the safety of patients, personnel and visitors.

The department's participation in the facility's overall security plan will be evaluated.

Linked criterion:
7.4.1.4

38.9.1.4 Fire safety measures are implemented.

The department's participation in the facility's overall fire safety programme will be evaluated.

Linked criterion:
7.5.1.1

38.9.1.5 The organisation's policy on handling, segregation storing and disposing of healthcare waste is implemented.

The implementation of the facility's master policy will be evaluated in the department. The process must include handling at source, collecting, storing and disposing of clinical waste.

Linked criterion:
7.7.1.1