COOPERATION
PAKISTAN
FEDERAL REPUBLIC OF GERMANY

Secondary Care Standards for Quality Health Services in NWFP - Version 1

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gtz

Health Regulatory Authority N.W.F.P

N.W.F.P

EPOS Health Consultants

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1. INTRODUCTION

This manual of standards for quality services in secondary health care facilities has been developed under the auspices of the Health Regulatory Authority (HRA). The HRA is designated by the Government of NWFP to function as the regulatory body for public and private health services in NWFP.

The standards provide a framework for the HRA to assess the quality of care provided in public and private health facilities and a framework for public and private hospitals to assess and improve quality in a structured manner. In this way, they are a useful management tool for individual hospitals to identify their strengths, gaps and areas for improvement and provide one mechanism for the Government of NWFP to identify priority areas for overall improvements in the healthcare delivery system.

This standards manual is a first draft and will be field-tested during 2007 by professionals in hospitals in NWFP. Once the final draft is agreed upon, the HRA will lead a regular review and update of the standards.

The standards are patient/client focused and include a section on patients' rights putting emphasis on the involvement, empowerment and education of the patients. The standards are also focussing on processes and provide a basis for identifying and improving core patient care, management and support processes within the hospital. Outcome orientation is supported through the inclusion of performance indicators.

1.1 How the Standards Have Been Developed

The NWFP Standards for Secondary Health Care are based on Hospital Standards developed by EPOS Health Consultants within the GTZ-funded Basic Health Project Himachal Pradesh, India. The Himachal Pradesh (HP) Hospital Standards are based on the fourth edition (1999) of the British HAP Standards, which were developed especially for smaller hospitals from 1986 onwards by the Hospital Accreditation Programme, a not-for-profit organisation run by CASPE Research, London.

To adjust the HP standards to the needs and the reality of the hospitals in NWFP, they were tested in a small number of public and private hospitals in NWFP. After the initial testing, a first revised draft was prepared by two EPOS Consultants contracted by GTZ, which was presented to and discussed with health professionals in NWFP.

In December 2006, the different sections of the standards were reviewed and revised by specialists and experts during a series of workshops. Experts were drawn from, private, public and NGO organisations, the Department of Health, Medical Associations, district and teaching hospitals, and other hospital support service areas. The HRA as the owner of the standards took a leadership role in developing them.

Those participating in the workshops were invited to evaluate whether the Standards and their criteria were:

- Relevant
- Important
- Understandable
- Measurable
- Achievable

According to the outcome of this evaluation, the participants where asked to make suggestions in relation to the Standards and criteria on whether to:

- adopt them
- adapt them to the needs of NWFP
- delete them
- add additional Standards and criteria relevant to NWFP

1.2 Structure of the Standards

The hospital standards consist of the following five parts:

Part A: **Management**

Part B: **Service Delivery**

Part C: **Auxiliary Services**

Part D: **Infection Control, Hygiene and Waste Management**

Part E: **Safe and Appropriate Environment**

Each part consists of a number of chapters. Each chapter includes "**standards**" and "**measurable criteria**". Whereas "standards" are broad statements of the expected level of performance, the "measurable criteria" make the standards operational and provide details on structures and processes necessary to ensure high quality of care. The standards and their criteria have been specifically developed for the NWFP hospital setting by the working groups.

1.3 How to Use the Standards

The Hospital Standards, together with the assessment tool which will be developed in 2007, provide a framework either for self-assessment or for external assessment and peer review. They can also be used for planning purposes. Based on an assessment of the strengths and areas for improvement in the hospital, priority areas for improvement can be identified and quality improvement activities started. The Standards also provide guidance when problems and questions about quality arise in the daily work of hospital staff.

PART A: MANAGEMENT

1. MANAGING THE ORGANISATION

1.1 Mission and Strategic Planning

The hospital is directed and managed effectively and efficiently, in accordance with its objectives and mission statement.

No.	Measurable Criteria
1.1.1	There is a universal mission statement for the Hospital, which sets out the principal aims of the Hospital and which is developed together with staff, client representatives, representatives of the owners and other relevant stakeholders.
1.1.2	A defined set of values guides the behaviour of the hospital staff
1.1.3	The mission and values are available and disseminated to the staff and general public in languages and forms appropriate to the local population and their needs.
1.1.4	A strategic plan developed in consultation with the staff and other relevant stakeholders sets out the long-term goals, objectives and strategies for the hospital and its services.
1.1.5	An annual plan is developed in line with the strategic plan and contains objectives, planned actions and staffing, financial and physical resources to meet the planned actions.
1.1.6	Progress against the objectives and planned actions set out in the annual plan is reviewed regularly according to a defined monitoring and evaluation process.
1.1.7	The strategic and annual planning is based upon a SWOT analysis, including an analysis of community and patient/client needs, service delivery and evaluation data, current health policies and other relevant information.
1.1.8	A coded hospital management information system is in place and provides data for the annual planning process

1.2 General Management

Responsibilities for operating the organisation, managing its resources and for complying with applicable laws and regulations are clearly documented.

No.	Measurable Criteria
1.2.1	The Hospital is overseen by a Governing Board (Board of Directors/ Representatives of Government Department).
1.2.2	The Governing Board provides leadership and is responsible for: - establishing and reviewing the mission, values and strategic direction of the hospital - fostering a culture of quality improvement - ensuring the hospital is adequately resourced to meet its objectives - ensuring compliance with all relevant legislative requirements - monitoring and evaluating the achievement of strategic and annual results.
1.2.3	The Hospital is managed by a Hospital in-charge with appropriate qualifications and experience.
1.2.4	The job description of the Hospital in-charge clearly defines responsibility and accountability for the efficient and effective operation of the hospital, including responsibility for risk and quality management, infection control and health and safety.
1.2.5	A current organisational chart identifies the lines of accountability and reporting for all staff and the governing authority/owners
1.2.6	The organisational chart is regularly reviewed and clearly communicated to all staff within the

No.	Measurable Criteria
	Hospital and other relevant persons.
1.2.7	Clear and effective mechanisms exist for internal and external communication. These include: - Two-way communication between staff and between staff and management - Communication between different departments and wards - Communications with the press and media - Communication with patients/carers - Communications with external organisations
1.2.8	Staff follow a clear policy on confidentiality and release of information which complies with the local acts and rules.
1.2.9	The scope and limits, roles and functions of each clinical service/unit/department are clearly defined and known to staff and are determined with the input of staff.
1.2.10	Each service within the hospital is led by an identified manager with appropriate qualifications and experience who is responsible for the organisation and management of this service.
1.2.11	Duty rotas reflect the appropriate skill mix and health authority requirements and are available at least two weeks in advance.

1.3 Risk and Quality Management

The hospital prevents and manages risks, identifies opportunities to continuously improve its processes and services, makes improvements and evaluates their effectiveness.

No.	Measurable Criteria
1.3.1	A risk management plan for the Hospital: - is based on information from business planning and results, client/patient feedback, clinical indicators and events, staffing and resource provision, and environmental data - identifies, assesses and prioritises all risks in terms of likelihood and consequences of harm/damage - includes strategies to manage those risks and - is available and disseminated to staff.
1.3.2	Incidents, accidents, near misses and adverse events are: - reported on the appropriate form - investigated promptly according to a set procedure - used to make improvements in line with any findings and - communicated to staff.
1.3.3	Incident, accident, near miss and adverse event data are collated into a central record, analysed and reported to the Health and Safety and/or Infection Control and/or Quality Committee for information and action as required.
1.3.4	There is a group on quality which meets on a regular, documented basis to analyze reports, and to monitor, support, advise and lead on quality improvement. Staff have input into this group.
1.3.5	Staff are educated on how to reduce risk, including: - detecting, assessing and reporting risk situations - managing unsafe behaviour or situations - preventing and controlling infection - using equipment and supplies safely - safe transferring and lifting techniques.
1.3.6	The quality group develops a quality plan which defines roles and responsibilities and sets priorities for quality improvement.

No.	Measurable Criteria
1.3.7	Performance indicators for priority diseases and key processes, e.g. waiting times, re-admission rates, medication errors, infection rates and accidents, are measured, reported and used for improvement
1.3.8	The hospital regularly assesses client/patient satisfaction in order to improve service provision.
1.3.9	Staff follow documented policies and procedures for the key functions and processes in each service and department.
1.3.10	Policies and procedures are - up to date - developed with the input of staff - readily accessible to staff in their units and departments - formally reviewed at least every two years or as circumstances change and revised as necessary.
1.3.11	Appropriate and evidence-based clinical guidelines are developed or adopted and made available to all staff within the hospital.
1.3.12	Staff are trained to follow the guidelines and there is evidence that they do.
1.3.13	A clinical audit schedule is agreed between management and clinical staff and implemented.
1.3.14	Improvements are planned, appropriate action is taken, the effectiveness of the action is evaluated and the results are fed back to staff and clients/patients.
1.3.15	Sufficient financial resources to implement the quality improvement plan are available and all relevant staff are allocated time for quality improvement activities.
1.3.16	Information on hospital services, developments, improvements and quality outcomes are shared with the community.

1.4 Financial Management

Financial resources are managed efficiently and effectively in order to optimise services that can be provided and results that can be achieved.

No.	Measurable Criteria
1.4.1	A qualified financial manager is responsible for financial management and developing rules and procedures which are followed and monitored.
1.4.2	The Hospital in-charge and departmental heads are involved in setting annual targets and budgets for the following financial year.
1.4.3	Monthly budget statements are provided for the Hospital in-charge and departmental heads within two weeks of the previous month to assist them to manage their services.
1.4.4	The accounting system produces reliable financial information on all sources of revenues (line budget, grant in aid, user fees, zakat, donations, health insurance fees or others) and all expenditure, and provides timely and accurate financial reports for decision making.
1.4.5	An internal control and audit system is in place.
1.4.6	An external financial audit is undertaken annually.
1.4.7	A mechanism is used to control the acquisition, use, disposal and safeguarding of assets in accordance with financial rules and regulations.

1.5 Human Resources Management

Staff are appointed, trained and evaluated in accordance with documented procedures, job descriptions and service needs.

No.	Measurable Criteria
1.5.1	The hospital develops and implements policies and procedures for the management of staff, which includes appointment, selection, training, appraisal, promotion, and retention of appropriately qualified staff to meet the service objectives of the organisation.
1.5.2	Staff availability and skill mix are consistent with the on-going role and functions of each unit
1.5.3	Records are available which show: - Staff levels and skill mix - Workload and complexity - Sickness and absence - Training.
1.5.4	Staff appointments are made in line with the required qualification and experience for the job.
1.5.5	Staff are treated in accordance with an equal opportunities policy and as per Government rules.
1.5.6	Current job descriptions and responsibilities for all staff are available and all staff have a copy of their job description.
1.5.7	All new staff have their professional registration papers checked on appointment and regularly thereafter to ensure employees have a current valid registration with the relevant professional accreditation body.
1.5.8	All staff are oriented to the hospital and their specific positions through a documented induction program.
1.5.9	The induction programme includes: - The hospital's mission, values, goals and relevant planned actions for the year - Services provided - Roles and responsibilities - Relevant policies and procedures, including confidentiality - Use of equipment - Safety - Emergency preparedness - - Quality improvement.
1.5.10	Every staff member in the hospital can be identified by appropriate mechanisms, e.g. uniforms, name tags, hats.
1.5.11	Staff performance is evaluated annually with the staff member against their job description and agreed targets and is used to identify strengths, areas for improvement and training needs.
1.5.12	A mechanism exists to monitor that all doctors, nurses, midwives and other health professionals have had sufficient recent practice to maintain competence and to address any competence issues through additional supervision, training or other procedures.
1.5.13	The hospital identifies staff authorised as competent to undertake admissions, carry out assessments, provide treatment in different services and maintain and manage waiting lists.
1.5.14	Student nurses, doctors or other health professionals are supervised by a qualified nurse, doctor or other health professional as appropriate.
1.5.15	Staff facilities include: - Rest room - Changing facilities - Personal lockable storage area - Washing/shower facilities - Toilets - Refreshment facilities - Refreshments for on-call/on-duty staff at night

No.	Measurable Criteria
	- Accommodation for on-call staff in the Hospital premises - Staff housing.
1.5.16	There are appropriate facilities for staff representatives including access to a meeting room.
1.5.17	A training needs assessment exercise is conducted every two years with the objective of developing training plans for all staff groups in order to meet the development needs of individual health professionals and the service needs of the organisation.
1.5.18	A continuing education programme is accessible to all staff. Participation is encouraged and monitored by the hospital.
1.5.19	There is a training budget, which is calculated to allow appropriate training to take place.
1.5.20	Accurate and complete personnel records, including records of training, are kept in a secure location and treated as confidential.
1.5.21	Key indicators such as absenteeism and staff turnover are measured and the results analysed and used for improvement.

2. CLIENT/PATIENT RIGHTS

2.1 Information for Clients/Patients

Clients/Patients have the right to receive all information relevant to their care management to enable them to make informed decisions.

	Measurable Criteria
2.1.1	A client/patient rights and responsibilities charter is developed and displayed in all client/patient areas.
2.1.2	The hospital uses a documented process for clients/patients not able to understand written information to inform them of their rights.
2.1.3	Guidance and advice is provided to the clients/patients at the registration counter.
2.1.4	The reception area and wards display information about the organisation, including: - The rights of the clients/patients - Services and facilities available in the hospital - Costs of services - Feedback and complaints pathways.
2.1.5	Information about the hospital services and how best to use them is made available to the public and displayed in a prominent place.
2.1.6	Clients/Patients and their families are fully informed about the client's/patient's health status, including the clinical facts about their condition, unless they explicitly request not to be informed.
2.1.7	Appropriate information is provided to clients/patients and their families, in a way that they can understand, on the proposed treatment, the costs, the risks and benefits of the proposed treatment or investigation, and the alternatives available.
2.1.8	Client/Patient consent is obtained for the proposed care or treatment. Written consent is obtained for any invasive procedures or operations.
2.1.9	Information related to referral to a different hospital such as cost, travel, time, duration of treatment and expected outcome is provided to the client/patient and their family.
2.1.10	Up-to-date and evidence based information and education are given on: - Disease prevention - Health promotion
2.1.11	Relevant health messages are prominently displayed within the hospital and written information is available for clients/patients to take home.
2.1.12	Client/Patient choices and preferences are considered when care and services are being provided and ward activities arranged.
2.1.13	The hospital has determined its level of responsibility for clients'/patients' possessions and clients/patients receive information about the hospital's responsibility for protecting personal belongings.

2.2 Client/Patient Feedback on Services

Clients/Patients have the right to complain about the services and treatment and their complaints are investigated in a fair and timely manner.

	Measurable Criteria
2.2.1	Clients/Patients are informed of their right to express their concerns or complain either verbally or in writing
2.2.2	There is a documented process for collecting, prioritizing, reporting and investigating

	Measurable Criteria
	complaints which is fair and timely.
2.2.3	Clients/Patients are informed of the progress of the investigation at regular intervals and are informed of the outcome.
2.2.4	The results of the complaints investigations are used as part of the quality improvement process

2.3 Privacy and Dignity of Clients/Patients

Clients'/Patients' privacy and dignity are respected throughout the entire care process.

	Measurable Criteria
2.3.1	Clients/Patients have (a right to) individual beds.
2.3.2	Consultation, treatment rooms and washing facilities allow privacy and separate toilets for male and female clients/patients are provided.
2.3.3	Appropriate in-patient and changing facilities for clients/patients allow privacy and dignity to be maintained.
2.3.4	A given intervention may be carried out only in the presence of those persons who are necessary for the intervention unless the client/patient consents or requests otherwise.
2.3.5	There is a process to identify and respect the client's/patient's values and beliefs.
2.3.6	Clients/Patients are relieved of pain and suffering according to the current state of knowledge.
2.3.7	The needs of dying clients/patients are assessed and documented.
2.3.8	Staff are made aware of the needs of dying clients/patients and provide respectful and compassionate care and services to dying clients/patients and their families.

PART B: SERVICE DELIVERY

3. CARE CONTINUUM

3.1 Access to Health Services

Services are continuously available and the hospital minimises physical, economic, social, cultural, organisational or linguistic barriers to access.

	Measurable Criteria
3.1.1	Access ways and passageways are kept clear at all times.
3.1.2	Disabled parking spaces are conveniently located, adequate parking areas are available for private and official vehicles and there is a designated area for public transport.
3.1.3	Functional wheel chairs and stretchers are available at the gate/reception for patients who are unable to walk.
3.1.4	All patient areas of the hospital are easily accessible by wheelchair.
3.1.5	Multi-storey buildings have ramps or functional lifts with an operator.
3.1.6	The hospital and its departments are clearly signposted and a site plan is displayed at a central place for orientation of staff and patients.
3.1.7	A reception with a male and female receptionist to guide the patients is open during operating hours.
3.1.8	The hospital specifies visiting hours (6 hours) and communicates these to the public.
3.1.9	Rules for numbers and kind of visitors and attendees are clearly defined and visibly posted and facilities enable relatives to sit at the bedside and to stay overnight.
3.1.10	Documented policies and procedures for the following processes are developed and followed by the staff: - Prioritizing patients with emergency needs - Examination and treatment of emergency patients and elderly patients - Management of patients when bed space is not available on the desired ward - Patient referral - Managing waiting time - Support to disadvantaged patients, such as unaccompanied and poor patients.
3.1.11	On admission to hospital, clients/patients are introduced to the nurse on duty and given an orientation to the unit to which they are admitted including the location of toilets, pantry and other facilities and services.
3.1.12	Clients/Patients admitted to the hospital have access to an allotted bed with fresh linen and do not have to double up with other clients/patients.
3.1.13	Elective admissions, including waiting list management and vetting, appointments and cancellations are managed in accordance with documented policies and procedures and based on client/patient need.

3.2 Continuity of Care

Clients/Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their diagnosis, treatment and care.

	Measurable Criteria
3.2.1	Every client/patient seeking treatment or care at the hospital is registered and issued the appropriate form for recording various details of symptoms, diagnosis, treatment and services

	Measurable Criteria
	being provided.
3.2.2	All clients/patients and visitors to the hospital receive courteous and prompt attention from the staff at reception and any ward or department.
3.2.3	The doctor on duty has primary responsibility for the clinical care of any client/patient until a specialist takes over.
3.2.4	The nurse on duty is responsible for coordinating client/patient assessment, care planning and evaluation of care with other care providers and services.
3.2.5	A stock of essential drugs is available at all times in each treatment area.
3.2.6	A staff/patient ratio based on international good practice is used for determining the number and mix of clinical staff on each shift, e.g. one qualified nurse to 10 patients and one doctor for 25 patients
3.2.7	Doctors, qualified nurses and appropriate support staff are available on-site 24 hours per day.
3.2.8	Nursing staff can summon urgent medical help if required.
3.2.9	Regular meetings of different care providers are held to share information on clients'/patients' progress and client/patient care is formally handed over with the transfer of all relevant information when staff change duties.
3.2.10	The client's/patient's record is available to all care providers.
3.2.11	Planning for discharge or end of service begins at admission and involves the client/patient and their family and potential providers of follow-up services.

3.3 Assessment

All clients/patients have their health care needs identified through an established assessment process.

	Measurable Criteria
3.3.1	Assessments are carried out by qualified professionals identified by the hospital as competent to do assessments.
3.3.2	Criteria to prioritise emergency patients exist and are implemented.
3.3.3	Clients'/Patients' choice regarding examination by a male or female is respected as far as possible.
3.3.4	An attendant is available when patients are being examined by members of the opposite sex.
3.3.5	An assessment of the patient's/client's needs is systematically completed on an agreed form including, for example, medical, psychological, social, physical, environmental, educational, spiritual and cultural needs.
3.3.6	The initial assessment includes the recording of vital signs, weight, height and significant findings.
3.3.7	The client's/patient's relatives and carers are included in the assessment by providing information wherever possible.
3.3.8	A history and full medical examination is entered in the patient records by a member of the medical staff as soon as possible but at the latest 6 hours after admission.
3.3.9	After examining the client/patient, the doctor legibly endorses the assessment findings, records the provisional diagnosis and the course of action on the OPD card or the client/patient record and dates and signs it.
3.3.10	Except in an emergency, admission notes are completed prior to any surgical procedure.
3.3.11	Following examination, written as well as verbal information is provided for clients/patients regarding future visits, treatment and medication.

	Measurable Criteria
3.3.12	Clients/Patients are re-assessed at certain intervals to determine their response to treatment and to plan for continued treatment or discharge and re-assessment results are documented in the client's/patient's record

3.4 Care Planning, Monitoring and Evaluation

Health Care Providers develop and implement a written, up to date plan of care/service for each client/patient and monitor the care provided against this plan.

	Measurable Criteria
3.4.1	A written care plan for each client/patient is prepared in collaboration with the client/patient, carers/relatives and other appropriate health professionals.
3.4.2	Care plans identify the goals of care and treatment and reflect the client's/patient's assessed needs, perceptions and priorities, agreed philosophy of care, current practice guidelines and evidence-based practice.
3.4.3	The care plan includes how the client's/patient's individual choices and preferences are to be addressed.
3.4.4	The care plan is evaluated and updated in accordance with the findings of re-assessment and progress in meeting identified goals.
3.4.5	The care plan is used by doctors, nurses and other health professionals to facilitate continuity of care and on-going appropriate treatment.
3.4.6	Outcome indicators, e.g. hospital acquired infections, leg ulcers, client/patient complaints, are systematically monitored, recorded, analysed and used to improve care.

3.5 Treatment

The organisation delivers services to the clients/patients that meet their individual assessed needs, reflect current good practice and are co-ordinated to minimise potential risks and interruptions in provision.

	Measurable Criteria
3.5.1	Clinical guidelines/treatment protocols are used to guide client/patient care processes.
3.5.2	Policies and procedures guide the care of high-risk clients/patients, such as: - emergency clients/patients - those who are comatose or on life support - those with communicable diseases or who are immune suppressed - clients/patients on dialysis - vulnerable elderly and children - seriously ill clients/patients.
3.5.3	Written procedures to ensure that the right dose of medication is administered to the right client/patient at the right time are followed by staff and include: - Identification of the client/patient before medications are administered - Verification of the medication and the dosage amount with the prescription - Verification of the routes of administration - Verification of the time of administration.
3.5.4	Medication effects (including adverse effects) and medication errors are monitored, reported and analysed.
3.5.5	Appropriate and sufficient support services are available to allow nursing staff to meet the care needs of clients/patients. These include:

	Measurable Criteria
	- At least one Class IV employee around the clock - Equipment of at least B.P. Apparatus, Stethoscope, Thermometer, Oxygen cylinder with trolley, Suction machine, torch and nebuliser.
3.5.6	Clients/Patients are not disturbed during meal times for medical rounds, nursing or other treatments, other than in an emergency.

3.6 Documentation of Care

The client/patient record contains sufficient information to identify the client/patient, support the diagnosis, justify the treatment and care, document the course and results of the treatment and care, and promote continuity of care among health care providers

	Measurable Criteria
3.6.1	A clinical record is initiated for every client/patient admitted to the hospital and wherever possible there is only one set of case notes for each client/patient.
3.6.2	Client/Patient records are maintained through the use of a unique number or other form of identification unique to the patient.
3.6.3	Entries in the client/patient records are legible, dated, signed and identifiable.
3.6.4	The use of symbols and abbreviations is kept to a minimum in accordance with an agreed list of abbreviations within the hospital.
3.6.5	There is a locally agreed format for filing of information within the client/patient record.
3.6.6	The hospital respects information about a client's/patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind as confidential, even after death. Confidential information is only disclosed if the client/patient gives explicit consent or if the law expressly provides for this.
3.6.7	The client's/patients' record can be used for research purposes only if the client/patient has given a written consent and/or if there is an approval by the Ethics Committee.
3.6.8	The original client/patient record may not be removed from the hospital premises, except by court order. Policies and procedures are in place to prevent the loss and/or misuse of client/patient records.
3.6.9	The client/patient record is sufficiently detailed to enable the client/patient to receive effective coordinated treatment and care and includes**:** - Details of admission, date and time of arrival - Client/Patient assessment and medical examination - Sheet containing history pertinent to the condition being treated including details of present and past history and family history - Diagnosis by a registered health professional for each entry to the hospital - Details of the client/patient care or treatment plan and follow-up plans - Diagnostic test orders and results of these tests - Progress notes written by medical, nursing and allied health staff to record all significant events such as alterations in the client's/patient's condition and responses to treatment and care - Record of any near misses, incidents or adverse events - Medication sheet recording each dose given - Treatment record - Observation charts, e.g. temperature chart, input and output chart, head injury chart, diabetic chart - Specialist consultation reports - Mode of discharge, e.g. left against medical advice or discharge on will - In case of death, details of circumstances leading to the death of patients

	Measurable Criteria
3.6.10	- For surgical clients/patients, the clinical record additionally includes: - Anaesthetic notes - Operation record - Consent form.
3.6.11	Where referrals have been made, the client/patient record includes the referral letter and indications for referral
3.6.12	An 'alert' notation for conditions such as allergic responses to medications or food, adverse drug reactions, radioactive hazards and infection risks is prominently displayed in the record. For allergies, the case sheet and folder are stamped in bold red with the word ALLERGY
3.6.13	A completed discharge summary signed by the doctor (full name) who authorized the discharge is submitted to the records department within 72 hours of the client's/patient's discharge.
3.6.14	All diagnoses/procedures are coded using ICD 10 and a yearly summary report is prepared and used for planning.
3.6.15	Client/Patient records (hard copies) are retained for a minimum of 7 years and disposed of according to existing rules and legislation.
3.6.16	Appropriate policies and procedures are in place to govern access to and storage of patient records.
3.6.17	There is a clear policy which allows patients access to their records.
3.6.18	All patient records are filed in a central medical records filing system. There is a provision of a separate storage area for keeping medico-legal case records.
3.6.19	There is a system for easy retrieval of records.
3.6.20	The storage area for client/patient records is protected against fire, flooding and damage by insects consistent with the Govt. of Pakistan norms.
3.6.21	A tracking system monitors the removal, movement and replacement of client/patient records between internal users and the Medical Records Department.

3.7 Discharge, Transfer and Referral

Safe and appropriate discharge, transfer or referral of clients/patients is based on the client's/patient's health status and need for continuing care.

	Measurable Criteria
3.7.1	A written and dated procedure including criteria to determine readiness for discharge, transfer or referral of clients/patients is used and specifies who is authorised to do it.
3.7.2	Reasonable time, preferably 12 hours, of notice of discharge or transfer is given to clients/patients and carers.
3.7.3	Follow up arrangements, agreed with the client/patient and/or the family, are noted in the client/patient record prior to discharge.
3.7.4	On discharge, the attending doctor summarises in the client/patient record the primary (and secondary) diagnosis, any complications, any operative procedures undertaken and any follow up arrangements agreed with the patient/family.
3.7.5	A discharge card/slip containing relevant information such as reason for admission, findings, diagnosis, treatment, medication, condition at discharge, date of discharge and name of attending practitioner is signed and given to the client/patient and/or his family prior to discharge, with a copy retained in the client/patient record.

	Measurable Criteria
3.7.6	The health professional discharging the client/patient ensures that the following are given to the client/patient or relative/carer on discharge: - Medications, dressings or appliances - Instructions in a clear understandable manner on follow up, including as appropriate written advice and counselling regarding medications, diet, health problem management and exercise - Written details of out future appointments - Personal belongings.
3.7.7	The client/patient and/or the appropriate carer or attendant is advised on any necessary skills for care after discharge such as moving and handling techniques or catheter care.
3.7.8	If clients/patients are transferred to another hospital or doctor, copies of their clinical notes and the discharge slip accompany them to provide sufficient information for continuity of care and feedback
3.7.9	Clients/Patients being transferred to other facilities are provided with necessary resources such as transport, walking aids and documentation.
3.7.10	Before transfer the facility to which the client/patient is being transferred is informed about receiving the client/patient, their status and the time of arrival and afterwards the hospital checks with the facility that the transfer has been safely made.

4. OPERATION THEATRE DEPARTMENT

4.1 Service Management

Operating Theatres provide safe, hygienic and appropriate services for clients/patients and are co-ordinated with other services of the hospital to provide continuity of care.

No.	Measurable Criteria
4.1.1	The operating theatre and/or department is managed by a suitably qualified, registered and experienced nurse, doctor or senior operating department assistant.
4.1.2	A list of hospital approved surgical procedures based on an annual assessment of qualified staff, equipment and other inputs and processes is communicated to staff
4.1.3	Anaesthetic services are provided by qualified, registered and experienced anaesthetists.
4.1.4	An anaesthetist is present for all surgical procedures 24 hours a day.
4.1.5	A designated, suitably trained member of staff (Operating Theatre Assistant, anaesthesia technician) is available to assist the anaesthetist at all times.
4.1.6	A visiting consultant surgeon or assistant provide surgery, assistance and advice through a signed agreement specifying the limits of their consultation.
4.1.7	A signed agreement with a referral hospital offering more comprehensive services ensures provision of necessary surgeries.
4.1.8	Regular documented audits of the operating theatre are carried out and the information is used by relevant management, safety and/or quality improvement committees.
4.1.9	Any changes required to practice, provision or organisation as a result of the audits are discussed with all staff concerned before implementation.
4.1.10	ICD coded data available to OT staff from audits includes: - Admissions and discharges by speciality - Diagnosis-specific bed utilisation - Procedure-specific operating rates - Post operative infections - Post operative deaths - Unplanned return to theatre - Post operative pulmonary embolism - Post-operative CVA - Post operative cardiac myocardial infarction - Unplanned re-admission within 28 days of discharge - Unplanned transfer to ICU - Unplanned transfer to another unit - Unplanned second operation within 6 weeks of surgery - Damaged organs following surgical procedure.

4.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the operating theatre and/or department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

No.	Measurable Criteria
4.2.1	Written up-to-date procedures are available, followed by staff and include but are not limited to the following: - Signage of OT as a restricted area and identification of persons allowed in the OT - Sterilisation and identification of sterilised OT equipment

No.	Measurable Criteria
	- Separation and transport of dirty linen - Pre-operative assessment and instructions - Routine equipment check and preparation - Annual review of functioning equipment in line with the services offered by the OT - Sending for and the transportation of clients/patients from ward to OT - Admission to the operating department - Identification of clients/patients - Identification of operation site - Recovery - Inoculation injury - Staff protection against exhaust from anaesthetic gases - Post-operative care - Handover procedures for pre-operative and post-operative clients/patients - Diathermy use - Tourniquet use - X-ray use - Laser use - Swab, needle and instrument count - Infected clients/patients.
4.2.2	The following formal documentation/records are available in the department: - Theatre register (anaesthesia register and surgeons' register) - Prosthesis register - Electro medical equipment register - Record of correct swab/instrument count - Controlled drugs - Specimens register - Record of weekly/monthly analyses of surgeries (including the ICD 10 code) - Next-day schedule for operations - Maintenance of stock levels of drugs and consumables - Duty roster.
4.2.3	Specific safety rules and instructions are displayed and followed by staff for the following: - Storage and use of hazardous chemicals, e.g. glutaraldehyde, formalin - Storage and use of compressed gases - Appropriate shielding and protective clothing, e.g. for image intensification - Emergency electrical power supply (UPS, inverters, generators and emergency electric lights)
4.2.4	Surgical patients under fourteen are managed by surgeons, anaesthetists and nurses with paediatric qualifications and experience.
4.2.5	Children have (the right of) access to a parent prior to and during induction of anaesthesia, and during recovery.
4.2.6	All patients/clients undergoing surgery are identified by a bracelet or other unique identification method secured to the patient/client.
4.2.7	Full, non-abbreviated preoperative notes are kept for all patients/clients and include but are not limited to: - Signed evidence that informed consent to surgery has been obtained by a doctor for critical surgery and by the nurse for routine surgery - Signed evidence that the correct procedure was followed when obtaining consent for children under the age of 18 years - Details of the site and side of an operative procedure.
4.2.8	There is a separate fully functioning and equipped recovery room.
4.2.9	A trained recovery nurse is present for each anaesthetic session and remains in the

No.	Measurable Criteria
	recovery area until the last client/patient has been discharged back to the ward.
4.2.10	Sufficient, qualified and experienced staff monitor clients/ patients in the recovery room to ensure individual client/patient supervision at all times.
4.2.11	Documented discharge criteria are used to assess clients'/patients' readiness to leave the recovery room.
4.2.12	The anaesthetist is available in the hospital until the client patient has recovered from anaesthetic.
4.2.13	The anaesthetist provides the final authorization for the client/ patient to leave the recovery area.
4.2.14	There are clear, formal instructions on how to contact a doctor in an emergency.
4.2.15	A documented visit is made to each in-patient at least once by the surgeon, anaesthetist or MO between the first post-operative day and discharge.
4.2.16	A record of the operation for the client/patient record is made immediately following surgery and a copy is retained in the OT. The record includes the following: - Date and duration of operation - Anatomical site/place where surgery is undertaken - The name of the operating surgeon(s), operating assistants including scrub nurse and the name of the consultant responsible - The ICD 10 coded diagnosis made and the procedure performed - Description of the findings - Details and serial numbers of prosthetics used - Details of the sutures used - Swab and equipment count - Immediate post-operative instructions - The surgeon's and scrub nurse's signatures.
4.2.17	Anaesthetic records contain: - Date and duration of anaesthesia - Name of surgical operation performed - The name of the anaesthetist, anaesthesia assistant and, where relevant, the name of the consultant anaesthetist responsible - Pre-operative assessment by the anaesthetist - Drugs and doses given during anaesthesia and route of administration - Monitoring data - Intravenous fluid therapy - Post-anaesthetic instructions - Any complications or incidents during anaesthesia - Signatures of anaesthetist and anaesthesia assistant.

4.3 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients undergoing procedures in the operating theatre(s).

No.	Measurable Criteria
4.3.1	Arrangements are made so that hospital OTs are situated separately from areas accessible to the general public.
4.3.2	Hazard and/or warning notices are clearly displayed before restricted and high risk areas.
4.3.3	Changing facilities are provided for theatre staff to enable those entering the theatre to not cross "dirty" areas.
4.3.4	Separate male and female changing and rest rooms are available.

No.	Measurable Criteria
4.3.5	There is a clear separation of 'dirty' areas and OT (s) and only persons wearing theatre dress enter the OT(s).
4.3.6	Staff use a separate space for maintaining records and other office activities.
4.3.7	The anaesthetic induction area/room and operating theatre are equipped with safe and well maintained equipment specific for OT activities including but not restricted to the following: - Anaesthetic machine and ventilator - Laryngoscopes - Endotracheal tubes/laryngeal masks - Airways - Nasal tubes - Suction apparatus and connectors - Oxygen - Drugs and IVs required for planned anaesthesia - Drugs for emergency situations - Monitoring equipment including ECG, ETCO2, temperature monitoring, pulse oximeter and blood pressure - Accessible defibrillator - Anaesthetic gas scavenger system - Tipping/tilting trolleys/beds - Multi positioned table with radiolucent tops - Suction machine - Instrument cleaning/decontamination facilities - Temperature and humidity control - IV canulas and CV lines in different sizes - Blood warmer - Adequate light sources - Special equipment for particular age groups, e.g. neonate resuscitation table.
4.3.8	A list of additional items needed for special procedures and surgeries carried out by the OT is available in the theatre.
4.3.9	The recovery area is well lit and adjacent to the operating theatre.
4.3.10	Resuscitation equipment and drugs are immediately accessible in the recovery area.
4.3.11	A list of functioning equipment available in the recovery room includes :- - Airways (Ambu bags) and other intubation material and equipment - Suction - Oximeter - ECG - Tipping/tilting trolleys/beds - Blood pressure measurement apparatus - Defibrillator - Anaesthesia machine - Oxygen concentrator - Emergency ventilator.

5. CASUALTY DEPARTMENT

5.1 Service Management

The Casualty Department provides safe, timely and efficient live-saving emergency care and minor treatment and surgery for clients/patients.

No.	Measurable Criteria
5.1.1	The casualty department is managed at all times by a suitably qualified and experienced nurse, doctor or senior casualty department assistant.
5.1.2	Deputising arrangements for suitably qualified and experienced deputies are documented and used.
5.1.3	A signed agreement and close professional links with other emergency units offering more comprehensive services enables the provision of necessary emergency services.
5.1.4	Data and outcome indicators are systematically recorded and aggregated for analysis. These include a documented review of volume of activity, source and appropriateness of referrals and adverse events.
5.1.5	Data available for clinical review includes: - Number of attendances - Repeat visits - Clients/Patients who died in the casualty department.

5.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the casualty department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

No.	Measurable Criteria
5.2.1	Written procedures and guidelines are used consistent with the policy for: - Identifying which clients/patients should be seen immediately by a doctor in the department - How medical help is summoned in emergency - Dealing with life threatening emergencies before medical help arrives - The transfer of clients/patients - The transfer of records - The use of tele-medical techniques.
5.2.2	The hospital disaster plan clearly identifies the role, procedures and individual staff responsibilities within the casualty department in the event of a nearby major incident or disaster.
5.2.3	All clients/patients are seen within fifteen minutes of arrival for initial assessment and treatment prioritisation.
5.2.4	Each client/patient is informed of the approximate waiting time after the need for treatment has been assessed.
5.2.5	A process is used to monitor client/patient waiting times.
5.2.6	Clients/Patients are examined in privacy by a doctor of the same sex as the client/patient (if available), or have the service of a chaperone if desired.
5.2.7	Relatives are kept informed of the client's/patient's condition with the agreement of the client/patient where they are able to give such consent.
5.2.8	Locally agreed policies and procedures, consistent with local and/or national guidelines, are used for:

No.	Measurable Criteria
	- Road traffic accidents - Major incidents - Assault - Domestic violence - Child protection - Rape - Psychiatric emergencies - Drug abuse - Suspected criminals - Suspected victims of crime - Police enquiries - X-ray requests - Requests for reports - Tetanus immunisation - Death in the unit.
5.2.9	An individual record of attendance is completed which contains: - Name - Address - Age/Date of birth - Next of kin - Occupation/School - Case number - Telephone number - Date and time of arrival - Time of examination - Diagnoses - Treatment - Minor surgery carried out - Specimens taken - Instructions for follow up - Doctor's or nurse's names and signatures - Medication given to/or taken away - Advice given on discharge.
5.2.10	A departmental register identifies all attendances, reason for attendance, diagnostic tests, treatment given and any referrals.
5.2.11	A formal mechanism (roster) known to all staff is used for identifying medical staff on duty and on call and is prominently displayed in the emergency care area.
5.2.12	A procedure exists for referral for specialist care if necessary.
5.2.13	An agreed policy is followed which defines under what circumstances, if any, nurses may issue or administer specific drugs (including tetanus toxoid) without a specific doctor's order.
5.2.14	The type and extent of minor surgery to be undertaken is defined and is consistent with the facilities, equipment and skills available on site.
5.2.15	A written, dated, signed policy on the referral, selection and treatment of clients/patients for minor surgery is followed.

5.3 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients attending the casualty department.

No.	Measurable Criteria
5.3.1	A mechanism exists for regular review of the design and appropriateness of the treatment facilities and medical and surgical supplies to assess whether they are sufficient for the work undertaken in the unit.
5.3.2	The casualty entrance is clearly signposted from outside the hospital.
5.3.3	A call bell is available if the entrance to the unit is locked.
5.3.4	Parking is available for clients/patients, including designated space for the disabled.
5.3.5	There is a canopy over the casualty entrance used by ambulances.
5.3.6	The doorways and access are suitable for wheelchairs and trolleys.
5.3.7	Emergency alarms are strategically sited within the unit to summon help.
5.3.8	Contemporary basic clinical textbooks and information are available for staff.
5.3.9	There is appropriate equipment for: - Resuscitation - Monitoring - Minor operations - Sterilisation - X-rays and other imaging (either locally or by referral).
5.3.10	Hallways, clinical and public areas are clear of equipment, beds or other obstructions.
5.3.11	Treatment areas afford the clients'/patients' privacy.
5.3.12	A private area/room is available for interview and examination.
5.3.13	The waiting area: - has beverage facilities - has comfortable and adequate seating - is clean and secure.
5.3.14	There are toilet facilities suitable and available for males, females and disabled.
5.3.15	A public telephone is available for the use of clients/patients and relatives.
5.3.16	There is an accurate and functioning clock.

6. INTENSIVE CARE UNIT

6.1 Service Management

The Intensive Care Unit is managed by suitably qualified staff and organised to provide safe and efficient care for seriously ill clients/patients who need to be continuously monitored.

No.	Measurable Criteria
6.1.1	A qualified professional with relevant training in intensive care is responsible for overall co-ordination of the unit and is accessible for specialist advice.
6.1.2	A designated deputy is responsible for the management of the ICU in the absence of the manager.
6.1.3	An appropriately qualified, registered and experienced nurse is responsible for the day to day management of nursing care in the unit.
6.1.4	Staff are allocated on the basis of a systematic analysis of client/patient dependency and number of clients/patients.
6.1.5	All staff working in the unit are appropriately qualified and experienced for the work they do and have attended specialist high dependency care courses and continuous medical education for updating their skills.
6.1.6	Registered nurses in the unit have completed formal in-service training or a recognised course in intensive care and at least one is present on all shifts.
6.1.7	A suitably experienced doctor is immediately available at all times.
6.1.8	The Unit has a named person who leads on infection control issues (Microbiologist).
6.1.9	Relevant current texts are available for all staff for reference on the unit.
6.1.10	In private hospitals, the expenditure/cost of procedures in the ICU are clearly defined, displayed and given to the client/patient and/or the carer prior to admission.

6.2 Policies and Procedures

Operational policies and procedures which clearly describe the key processes of the ICU, the responsibility of the staff and expected results are followed by staff.

No.	Measurable Criteria
6.2.1	Specific policies and procedures include emergency admission to ICU from: - Theatres - Wards - Other departments - Outside.
6.2.2	Management policies and procedures are available and followed by staff for the following: - Airway management - Ventilators/respirators - Central oxygen supply and oxygen cylinders - CVP readings (central venous pressure) - Infusion pump management - Pulse oximeters - Cardiac monitors - Arterial lines - X-ray and other imaging investigations - Epidural care - Recovery facilities for all surgical cases where there is no dedicated recovery unit - Recovery care of major surgical cases.

No.	Measurable Criteria
6.2.3	Specific emergency procedures are available and followed for: - Apnoea/respiratory arrest - Inhalation of vomit - Cardiac arrest - Laryngeal spasm/stridor.
6.2.4	There are written criteria defining who is authorised to perform the following emergency clinical activities: - Intubation - Tracheotomy - Insertion of central lines - Defibrillation.
6.2.5	There are written policies and procedures agreed and followed for the following: - Clothing of staff and visitors - Filtering of clients'/patients' respired air - Changing of catheters, humidifiers and ventilator tubing - Isolation of at-risk or infected clients/patients - Cleaning of the unit.
6.2.6	Regular meetings take place to review cases and client/patient management, both within the unit and in conjunction with other departments.
6.2.7	The Unit discourages open visiting.

6.3 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients in the ICU.

No.	Measurable Criteria
6.3.1	There is sufficient space for storing disposable and consumable items.
6.3.2	A functional resuscitation trolley and defibrillator are available on the unit
6.3.3	Within the Unit, a designated member of staff is responsible for checking and recording daily and after each use: - Resuscitation equipment - Stockholding and date of resuscitation drugs.
6.3.4	Each bed has a central line facility for: - Oxygen - Suction - Compressed air - Central ECG monitoring.
6.3.5	Beds in the unit are arranged to allow ready access for routine and emergency procedures and are within direct vision of supervising staff at all times.
6.3.6	Adequate (at least three) numbers of power sockets are available for each bed.
6.3.7	Facilities in the unit include: - CVP monitoring - Pulse oximetry - Blood pressure monitoring (automatic) - Urometry - Ambient and client/patient temperature monitoring - Arterial blood gases - Glucometer - Electrolyte machine.

7. RESUSCITATION

7.1 Service Management

All professional staff are trained in resuscitation at least to basic life support levels. Those working in higher risk areas, e.g. casualty department, operating theatres and ICU are trained in advanced life support.

No.	Measurable Criteria
7.1.1	There is a written, agreed description of the scope and operation of resuscitation services provided within the Hospital.
7.1.2	A resuscitation training team exists within the Hospital and is responsible for the co-ordination of procedures, equipment and training of health staff both in the hospital and in the community.
7.1.3	The provision of resuscitation conforms to the recommendations of the Health Department and/or international guidelines.
7.1.4	There is a formal mechanism for obtaining specialist clinical advice on resuscitation issues.
7.1.5	There is a programme for regular in-service training of clinical staff in handling equipment and procedures for resuscitation throughout the hospital.
7.1.6	Records on training status are maintained for individual staff members.
7.1.7	All medical staff have received advanced resuscitation training at least every three years, by a trainer who has undertaken a recognised course and documentation is provided to show evidence of this.

7.2 Policies and Procedures

Policies and procedures related to resuscitation exist and are known to the staff.

No.	Measurable Criteria
7.2.1	Policies and procedures are reviewed as necessary but at least once a year.
7.2.2	An agreed, defined clinical procedure for resuscitation of adults (and children, if appropriate) exists and is followed by the staff.
7.2.3	An agreed, defined policy for when to use a defibrillator exists and is followed.
7.2.4	There is an agreed and written policy on the training of staff in the use of a defibrillator.
7.2.5	There is a policy for providing paramedic and medical assistance for resuscitation to the community.
7.2.6	There is an agreed policy for the management of anaphylaxis.

7.3 Facilities and Equipment

The Hospital provides adequate and functioning equipment for resuscitation in emergencies.

No.	Measurable Criteria
7.3.1	All staff providing resuscitation services carry pocket mask equipment.
7.3.2	Within the hospital, a designated member of staff is responsible for the checking and recording daily and after each use: - Resuscitation equipment - Stockholding and date of resuscitation drugs

No.	Measurable Criteria
7.3.3	Facilities available for resuscitation include: Mechanical - Resuscitation trolley containing equipment and medication for advanced life support - Defibrillator - Laryngoscopes (including for children, if appropriate) - Suction apparatus - Manual ventilation equipment e.g. bag, valve-mask, pocket mask - ECG monitor and leads Supplies (including for children if relevant) - Intravenous infusion sets - Endotracheal tubes and/or laryngeal masks - Oral airways - IV Cannulae Medications - Oxygen - Intravenous fluid - Resuscitation drugs.
7.3.4	All equipment is checked on a daily basis and after each use by suitably qualified staff. Records of the checks are kept with the equipment and monitored.
7.3.5	Endotracheal Intubation, cricothyroidotomy set and chest drainage equipment is only used by those experienced and trained in their use.
7.3.6	Facilities (equipment) are conveniently located within the hospital to be accessible to highest risk patients.

8. MATERNITY SERVICES

8.1 Service Management

Maternity services provide safe, timely and efficient maternity care for patients.

No.	Measurable Criteria
8.1.1	The maternity department is managed by a suitably qualified, registered and experienced nurse, doctor or senior midwife.
8.1.2	Deputising arrangements for suitably qualified and experienced deputies are documented and used.
8.1.3	A signed agreement and close professional links with a referral hospital offering more comprehensive services ensures provision of necessary emergency maternity services not available in the hospital.
8.1.4	The maternity department has 24 hour on-site cover from qualified medical doctors and an anesthesiologist.
8.1.5	Consultant obstetricians provide assistance and advice through a signed agreement.
8.1.6	Data for clinical audits and reviews is collected, analyzed and used for quality improvement activities and includes: - Number of women in ante-natal clinics - Numer of women with medical or surgical disorders in ante-natal clinics - Number of women transferred to higher-level care during pregnancy - Number of deliveries - Number of live and still births - Perinatal mortality figures - Maternal mortality figures - Number of transfers to specialist care during labour - Number of still births - Birth Registration records - Number of Caesarian sections - No. of difficult labour cases

8.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the maternity unit, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

No.	Measurable Criteria
8.2.1	Written procedures and guidelines are used consistent with the hospital policies and functions for: - ante natal care and booking/registration - post-natal care - peri-natal care - counseling for parenthood (e.g. family planning, genetic referral,) including, for example, IEC material - identifying high risk pregnancy - admission to labour room/ward - planning, treatment and mode of delivery - plan for managed pain during labour and delivery - delivery monitoring process

No.	Measurable Criteria
	- referral - discharge including discharge summary - birth record and certificate - labour register - immunization for mother and baby - infection control - disposal of placentas
8.2.2	A paediatrician is involved in the team developing and reviewing policies and procedures.
8.2.3	Each woman accessing the maternity department is cared for by a suitably qualified, registered and experienced nurse, doctor or senior midwife who she can contact for advice and help throughout her pregnancy.
8.2.4	Anesthetists with relevant qualifications and experience available for mothers with epidural, C Section, emergency breech and instrumental deliveries, emergency resuscitation and women with eclampsia.
8.2.5	A trained mid-wife/nurse is present at every birth.
8.2.6	A record of regular training in maternal and neonatal resuscitation is kept in the department for medical and nursing staff attending deliveries
8.2.7	A guideline on summoning medical assistance at anytime during labour is used by nurses and midwives
8.2.8	A roster indicates 24 hour arrangements for on-site availability of a suitably qualified and experienced doctor and an anaesthesiologist in case of an emergency.
8.2.9	Separate records are initiated and used for each baby.
8.2.10	Records kept after discharge include the combined: - Maternity notes (including care plans) - Birth registration(s) - Labour register - Admission register - Neonatal and perinatal morbidity - Neonatal and perinatal mortality - Maternal morbidity and mortality
8.2.11	Written procedures are followed by staff to arrange for consulting physicians, surgeons and pediatric physicians and surgeons for women or babies with medical or surgical needs such as multiple, high risk deliveries, instrument deliveries or C-sections.

8.3 Facilities and Equipment

Facilities and equipment are safe and adequate in design and number for the purpose and quantity of clients/patients attending/in the maternity department.

No.	Measurable Criteria
8.3.1	The delivery room is equipped with functioning, safe and well maintained equipment specific for deliveries including but not restricted to the following: - Fetoscope - Ultrasound machine - Delivery table which can be turned to the Trendelenburg position - An anesthetics machine with emergency oxygen supplies - Endotracheal tubes, laryngoscope - An incubator, with temperature adjustable for infants in need - Separate oxygen supply to the incubator - Resuscitation equipment and drugs for infants and for adults

No.	Measurable Criteria
	- Intravenous crystalloid and plasma expanders - Weighing machine for the baby.
8.3.2	Privacy for mothers is possible, e.g. when breast-feeding.
8.3.3	A separate room for seriously ill or intensive patients e.g. eclampsia, is available.
8.3.4	The area for labour provides for: - Space for the woman and a female companion - Alternative birthing methods - Ambulation throughout labour - Washing and toilet facilities for the comfort of the mother and companion
8.3.5	Lighting is versatile enough to provide a restful environment and allow birthing procedures to be performed.
8.3.6	The post-natal ward provides sufficient room for babies to room-in with mothers.
8.3.7	Nursery facilities with an even temperature and humidity are available, and are adequate in size with appropriate supplies and equipment for teaching mothers about caring for their babies.

PART C: AUXILIARY SERVICES

9. LABORATORY SERVICES

9.1 Service Management

The medical testing laboratory is managed and organised to provide efficient and effective laboratory care to patients and support services to clinicians.

	Measurable Criteria
9.1.1	The medical testing laboratory is managed by a suitably qualified and registered pathologist, experienced medical technologist or other suitably qualified and registered laboratory scientist. *(standards under development with HRA)*
9.1.2	A suitably qualified deputy is designated in the temporary absence of the laboratory manager.
9.1.3	Sufficient and appropriately qualified staff are available to fulfil the job descriptions of the defined service.
9.1.4	Laboratory staff participate in the health and safety committee, hospital quality committee and other relevant committees.
9.1.5	Departmental staff attend meetings of appropriate advisory /consultative bodies and have input into decisions affecting the laboratory.
9.1.6	A pamphlet outlines the list and prices of services offered, the types of specimens required and approximate reporting time for tests.
9.1.7	Laboratory staff inform in writing the designated hospital infection control committee of any infection identified in in-patient samples that could provide a risk to the hospital staff or clients/patients.
9.1.8	The service has a continuing education programme for staff development enabling staff to meet the needs of the hospital, the department, the individual and the clients/ patients.
9.1.9	Staff follow written policies and procedures for collection, transport and controlling, storing, reporting and disposing of all samples and tests in compliance with legal requirements.
9.1.10	Staff are involved on a regular basis in a quality management programme to monitor and improve the laboratory quality
9.1.11	Any outstation laboratory equipment is subject to the same quality control procedures as in the main laboratory.
9.1.12	The department has planned and systematic activities for the monitoring and evaluation of its services.

9.2 Samples and Tests

Laboratory samples and tests are managed to maximize accuracy of testing and minimise risks to patients/clients and staff.

No.	**Measurable Criteria**
9.2.1	A requisition form is used and includes the following: - Client/Patient information - Client/Patient location - Investigations required - Type of sample - Clinical history including clinical examination - Probable diagnosis

No.	Measurable Criteria
	- Requesting physician - Sample collection time - Name of phlebotomist.
9.2.2	Staff follow and communicate to clients/patients, verbally and in writing, procedures for the clients'/patients' preparation for tests.
9.2.3	Samples collected are labelled with the client's/patient's name, registration number, date and time of collection.
9.2.4	Separate labels are used for high risk samples.
9.2.5	Specimen trays are designed to enable safe transport.
9.2.6	The sample reception area receives, records, and verifies the samples or specimens.
9.2.7	A laboratory register records: - Client/Patient name, location - Identification of sample source(s) - Full name of the investigation(s) - Number of investigations - Investigation results
9.2.8	Samples are safely and accurately distributed to the respective sections of the laboratory.
9.2.9	Results are recorded in the laboratory register and on the reporting/result form.
9.2.10	Client/Patient Results Registers are readily accessible to staff.
9.2.11	Results are made available to the main reception of the laboratory to enable picking up by OPD, wards or clients/patients.
9.2.12	Signed and dated SOPs for each test and client/patient preparation for each test are readily available to staff in the laboratory.
9.2.13	Staff follow written, dated and signed procedures for: - Client/Patient preparation for tests - Completion of test request forms - Reporting of test results - Reporting results verbally - Dealing with out-of-hours test requests - Investigating transfusion reactions - Emergency and urgent requests - Storage of specimens and blood on the wards and in other departments - Dispatch of samples to other laboratories - Posting of samples - Acceptable parameters for response to test requests and reporting times.
9.2.14	Staff follow written procedures for samples: - Sample collection - Handling - Labelling - Transportation - Retention - Storage - Disposal of samples, including blood and body fluids.
9.2.15	The service is able to give immediate expert clinical advice on: - The appropriateness of tests - The samples required - The interpretation of results (expected and unexpected) - Further recommended tests.
9.2.16	Instructions are clearly displayed describing the safe disposal of clinical, toxic and radioactive waste.
9.2.17	Clearly labelled, separate containers are used for disposal of hazardous and infectious

No.	Measurable Criteria
	waste.
9.2.18	A written agreement exists, and staff follow this agreement, between the hospital and external laboratory covering all aspects of tests including time scales for reporting results.

9.3 Safety

All persons are protected from potential hazards in the laboratory.

	Measurable Criteria
9.3.1	A mechanism is in place to restrict access to the laboratory to authorised personnel only.
9.3.2	Health and safety policies, current relevant hazard notices and safety action bulletins are displayed as required or are readily available to staff, including but not limited to: - Safety regulations - Fire precautions - AIDS/HIV/ - Hepatitis.
9.3.3	Appropriate equipment is used for the safe handling of hazardous materials.
9.3.4	Action to be taken in the event of an infection emergency is known to all staff and is clearly stated in writing.
9.3.5	Staff are offered immunisations relevant to their type of work and emergency immunisations based on written policies.

9.4 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients served by the laboratory.

	Measurable Criteria
9.4.1	Laboratory and office space are sufficient to enable staff to carry out their jobs safely.
9.4.2	The laboratory environment is well lit, ventilated and not underground.
9.4.3	Staff have access to sufficient laboratory equipment to carry out their jobs safely.
9.4.4	Storage facilities for specimens and reagents are sufficient to enable staff easy access.
9.4.5	Refrigerated storage facilities are used for specified samples, specimens, and blood samples.
9.4.6	Functioning emergency electrical supply for refrigerators is available and there is a procedure in place to regularly assess its readiness.
9.4.7	Inspection, calibration and maintenance schedules are completed and used for all laboratory equipment.
9.4.8	Staff facilities include: - Locker space - Toilet and washing/shower facilities - Staff rest room - Overnight accommodation for on call staff.

10. RADIOLOGY

10.1 Service Management

Radiology services are managed and organised to provide safe and efficient care for client/patients and support to clinical specialties.
Note: Radiology services cover all services provided by a radiology department.

No.	Measurable Criteria
10.1.1	A radiologist (either on site or visiting) is responsible for the clinical direction of the department and the safety of the client/patients.
10.1.2	Radiology services are administered by an identified qualified, registered radiologist or radiographer with clearly defined responsibility for all non-clinical aspects of the department.
10.1.3	Trained, qualified radiographers, or in some cases radiologists, are the only staff who may take images.
10.1.4	There are on-call staff for mobile radiography and other imaging at all times.
10.1.5	Radiation protection is supervised by the radiologist and monitored by the Hospital in-charge and the Pakistan Nuclear Regulatory Authority.
10.1.6	Staff follow written policies and procedures for all aspects of radiology services, including: - Reception and registration of the client/patient - Preparation of the client/patient for imaging - Processing and interpreting the film or scan - Reporting on the film or scan - Documentation and despatch.
10.1.7	Up to date reference manuals, radiation regulations and guidelines, radiation safety reports, are available within the department.
10.1.8	The department participates in the Hospital's quality improvement system and monitors the quality of its services using an internal quality control programme which includes: - Equipment utilisation review - Performance checks on equipment, including processors - A record of maintenance checks for all items of equipment - Film and scan reject rates - Clinical audit - Turnaround times for the reporting of films and scans.
10.1.9	Radiology staff review the results of its quality control programme, take action on them in a radiology quality committee and participate in the hospital health and safety committee and other relevant committees.

10.2 Service Provision

Clients/patients are systematically registered, receive radiological services in line with written requests and have their x-rays reported promptly and accurately.

No.	Measurable Criteria
10.2.1	Clients/Patients are registered, assigned a registration number and given special instructions in a systematic way.
10.2.2	Request Forms are of a standard format and contain: - Client's/Patient's name - Identification number - National identity card number - Address

No.	Measurable Criteria
	- Date of birth (if not available, age/ - Examination requested - Previous examinations - Clinical diagnosis/indications/relevant history - Information relating to the pregnancy rule in women of childbearing age - Identity of requesting physician - History of allergy in red ink - For medico legal cases mark of identification of the client/patient and name of police official bringing the client/patient - Fee to be charged/not to be charged.
10.2.3	Diagnostic imaging is performed only upon a signed written request from a qualified medical practitioner.
10.2.4	Arrangements are in place for dealing with out of hours or emergency requests.
10.2.5	A written policy agreed with the radiologist defines the terms under which pregnant women may be subjected to radiological examination
10.2.6	All films are read by a radiologist and the written radiologists' reports are received by the hospital within a defined time after examination.
10.2.7	Required reporting times are based on the urgency of the situation, e.g. films or scans for emergency client/patients are reported within one hour and routine reports are reported within 24 hours.
10.2.8	If a radiologist is unable to report on the film in a timely manner a written, signed interpretation of the radiograph is made by an appropriate clinician whose skills are relevant to the area radio graphed, e.g. chest radiography by a chest physician or bone/joint radiography by an orthopaedic surgeon.
10.2.9	Critical or unexpected findings are discussed with the referring doctor.
10.2.10	Radiology reports or copies of the reports are filed in in-patients' medical files in the wards.
10.2.11	For out-patients the radiology report is written on the OPD slip.
10.2.12	A duplicate report is kept on file in the department.
10.2.13	A copy of X-ray films and scans in medico-legal cases are retained by the department.

10.3 Safety

Radiological services are provided in accordance with current radiation rules and regulations, risks are minimised and the safety of client/patients and staff are protected.

No.	Measurable Criteria
10.3.1	Signs warning women of childbearing age of the dangers of radiation in pregnancy are prominently displayed.
10.3.2	All examinations using ionising radiation are performed by suitably trained personnel.
10.3.3	Staff provide services in accordance with current ionising radiation regulations and statutory requirements
10.3.4	A written resuscitation procedure for the department is agreed with a radiologist, the radiographers and the medical staff and is implemented when required.
10.3.5	Emergency drugs and equipment including all resuscitation equipment are functioning, not expired, are readily accessible and are monitored.
10.3.6	An effective written procedure to summon help in an emergency is displayed prominently in the department and used by staff.
10.3.7	All staff working in radiology services attend update courses on resuscitation, current radiology trends and evidence based practice.

No.	Measurable Criteria
10.3.8	Protective clothing is provided and used where biohazards or radiographic equipment are present.
10.3.9	The radiologist in charge is responsible for ensuring that compliance with national guidelines is monitored: - Staff working with radiological equipment wear radiation monitoring devices - These devices are assessed and maintained in accordance with statutory regulations - Records of these tests are kept for the working lifetime of staff employed by the service.

10.4 Facilities and Equipment

Facilities and equipment are provided and maintained to maximise client/patient comfort and safety.

	Measurable Criteria
10.4.1	A separate registration area for clients/patients is provided and a toilet with washing facilities for special investigations is located adjacent to the examination room.
10.4.2	.A separate waiting area for males and females with adequate seating and separate male and female toilets and washing facilities are provided for the comfort of clients/patients waiting for services and for their families.
10.4.3	The appropriate hospital advisory committee (or its equivalent) with representation of radiology staff is consulted and has input into the provincial committee before any diagnostic equipment is installed.
10.4.4	All equipment is subject to tests on installation to ensure the equipment meets with contract specifications and confirms mechanical, electrical and radiation safety.
10.4.5	Records of these tests are kept in the department for reference.
10.4.6	The workload of each piece of diagnostic equipment and staff is defined and used for determining the resources needed for the department.
10.4.7	Radiology equipment is stable, functioning and installed only in properly lead protected rooms.
10.4.8	A planned preventative maintenance programme which includes photo monitoring is followed to keep equipment in sound working order.
10.4.9	There is a programme that provides for the replacement of imaging equipment on a timely basis according to a defined schedule.
10.4.10	The radiation safety of essential equipment is regularly monitored and reported on by the Pakistan Nuclear Safety and Radiation Protection Agency.

11. PHARMACY SERVICES

11.1 Management

The pharmaceutical service is managed and organised to provide efficient and effective pharmaceutical services through rational use of drugs within the hospital.

No.	Measurable Criteria
11.1.1	The pharmaceutical service is managed by a qualified, graduate and registered pharmacist.
11.1.2	A suitably qualified deputy with specified duties and responsibilities is designated in the absence of the pharmacist.
11.1.3	Sufficient and appropriately qualified staff are available to fulfil the job descriptions and the defined services.
11.1.4	A copy of the Professional Code of Ethics is readily available, known to the staff and followed.
11.1.5	A qualified pharmacist or designated deputy is on duty or on call outside normal working hours to provide a pharmaceutical service.
11.1.6	Staff follow written policies and procedures for ordering and purchasing, controlling, storing, dispensing and disposing of all medicines within the hospital in compliance with legal requirements.
11.1.7	There is a defined mechanism by which doctors and nurses can influence the level of pharmacy services provided.
11.1.8	The department monitors the quality of its services using an internal quality control program and staff participate in the Hospital's quality improvement system.
11.1.9	The pharmacy service provides a regular prescription monitoring service, locally, to ensure the safe, effective and economic use of medicines. This includes: - Identifying inappropriate medication - Monitoring adverse reactions - Monitoring dispensing errors - Checking adequacy of labelling of drugs and information on package inserts - Physical examination of drugs to assess their quality and expiry dates - A mechanism to encourage prescription of cost-effective and economical drugs.
11.1.10	The pharmacist is a member and secretary of the purchase committee.

11.2 Selection, Ordering and Purchasing of Medication

Selection and procurement of medication is appropriate to the scope of service, client/patient needs, and cost-effectiveness.

No.	Measurable Criteria
11.2.1	The hospital formulary is prepared in a collaborative process considering client/patient needs, services provided in the hospital, cost-effectiveness and evidence-based criteria.
11.2.2	The hospital formulary is in accordance with existing national guidelines, e.g. National Essential Drugs List (NEDL), National Hospital Formulary.
11.2.3	Written policies and procedures exist and are implemented for the following processes: - Tendering - Evaluation of tenders - Selection - Ordering

No.	Measurable Criteria
	- Reception and physical examination of delivered drugs.
11.2.4	Evaluation of tenders and selection of the provider occurs through a transparent process based on specific criteria including quality and cost.
11.2.5	The quality, quantity and expiry date of purchased medicines are checked upon receipt.
11.2.6	Samples of delivered drugs are sent to the Provincial Drugs Testing Laboratory for quality check on a routine basis.
11.2.7	A copy of the supply order is sent to the Medicine Coordination Cell (MCC) for information (in case of public hospitals).
11.2.8	The list of medications available in the hospital pharmacy is available to all units and displayed at the counter.
11.2.9	A process exists to obtain required medications not stocked or normally available in the hospital pharmacy.

11.3 Storage and Stock Management

Stock is stored and managed to ensure that medications are current, kept safe and are continuously available to meet the needs of clinical staff and patients.

No.	Measurable Criteria
11.3.1	Medicines are stored on shelves enabling: - Protection from the adverse effects of light, e.g. glass windows painted white, dampness and temperature extremes - Freedom from vermin and insects - Adequate ventilation.
11.3.2	Medicines for emergency use are stored in sealed tamper evident containers in all patient areas.
11.3.3	Adequate and secure storage facilities provided include: - A suitable metal cupboard or container for the storage of flammable and/or hazardous material - A functioning pharmacy refrigerator.
11.3.4	Controlled drugs are stored separately in a metal cupboard, securely fixed to the wall or floor, to comply with drugs regulations.
11.3.5	A storage area is used for outpatient prescriptions, controlled medicines register and all other records required.
11.3.6	Separate cupboards are provided for medicines for internal use, external use and reagents.
11.3.7	Stocks of medicine are supplied against a written order or by a pharmacy top up service.
11.3.8	Stocks of controlled medicines are ordered by an authorized doctor using a controlled medicines order book for internal use.
11.3.9	A formal stock control system is used by the department and for the hospital.
11.3.10	There is a stock list with agreed par levels for all wards and departments.
11.3.11	Medicines required in an emergency are available and replaced promptly after use.
11.3.12	All expired or recalled medicines, including unwanted medicines returned by clients/patients and unused controlled medicines, are safely disposed of in accordance with a written procedure.
11.3.13	A formal, written procedure is followed to action hazard warnings and medicine recalls.
11.3.14	A formal, written procedure is followed for retention of order forms, copy of delivery notes, stores receipt, and issue vouchers, and book of records (controlled drugs

No.	Measurable Criteria
	book/prescription drugs book) on the premises as provided for in the relevant laws.

11.4 Prescribing, Administration and Dispensing of Medicines

Prescribing, dispensing and administration of medications are safe, efficient and effective and promote best possible treatment outcome.

No.	Measurable Criteria
11.4.1	A system is in place to ensure that: - Prescriptions are only issued by authorized prescribers - Administration of medicine is done by, or under the supervision of, competent health personnel.
11.4.2	All prescriptions are legible and duly signed by a doctor, including the following: - Name - Diagnosis - Dose - Dosage form - Strength of medications.
11.4.3	Staff follow a written policy for the verbal ordering of medicines in emergencies which has been agreed by medical, nursing and pharmacy staff.
11.4.4	Medicines are dispensed by, or under the supervision of, a pharmacist in accordance with a written prescription from a qualified registered medical practitioner.
11.4.5	The client/patient is provided with written and verbal information on the prescribed medicine including: - The costs - The potential benefits and adverse effects - Risks of ignoring instructions - How to use the medicine safely and properly.
11.4.6	There is an approved hospital prescription/medication chart on which all medicines for an individual client/patient are prescribed and their administration recorded.
11.4.7	A pharmacy register records: - Client/Patient name and registration number - Date - Diagnosis - Medicine dispensed.
11.4.8	Staff follow written, dated and signed procedures on the following: - What medicines may be administered without a prescription and under what circumstances - Self medication - Use of antibiotics - Administration of IV drugs, narcotics, psychotropic substances and cytotoxics - Obtaining medicines after hours from hospital pharmacy - How to obtain medicines not available within the hospital pharmacy - Dealing with clients'/patients' own medicines.
11.4.9	Medical practitioners follow policies for antibiotic prescribing which include: - Restricting the use of broad-spectrum agents to minimise the development of resistant viruses and bacteria - Using prophylactic antibiotics only where their efficacy has been established.
11.4.10	Where procedures are in place for clients/patients to self medicate, the medicines are stored in a locked cupboard or drawer in the client's/patient's room.

No.	Measurable Criteria
11.4.11	Current editions of reference books, including pharmacopoeia, the copy of the National Essential Drugs List (NEDL)/hospital own formulary, standard treatment guidelines and other information booklets are available.

11.5 Facilities

Facilities and equipments are safe and adequate for the purpose and the number of clients/patients attending the pharmacy.

No.	Measurable Criteria
11.5.1	All doors, windows and hatches within the pharmacy can be locked.
11.5.2	There is a designated area for: - The receipt and unpacking of goods in wards - Segregation of expired and recalled drugs - Dispensing of medicines.
11.5.3	The pharmacy has an administrative area, which includes a desk, filing cabinet, telephone and other necessary equipment.
11.5.4	There is a specific drug information/reference area for use by hospital staff.
11.5.5	There is a designated waiting area for clients/patients.
11.5.6	A box or trolley containing those medicines which may be urgently required in the event of a cardiac arrest is available.
11.5.7	Where a medicine trolley is used to store medicines, it is lockable and secured to the wall when not in use.
11.5.8	Lockable medicine refrigerators with maximum and minimum thermometers are provided for medicines requiring cool storage. They are used solely for this purpose.
11.5.9	Temperatures are regularly monitored and recorded and action is taken where a temperature varies from an acceptable range.
11.5.10	Medicine keys are kept separate from other keys by a named member of staff

Relevant regulative and normative documents:

- Drug Act 1976
- NWFP Drug Rules 1982
- Pharmacy Act 1967
- National Essential Drugs List

PART D: INFECTION CONTROL, HYGIENE AND WASTE MANAGEMENT

12. INFECTION CONTROL

The organisation designs and implements a coordinated program to reduce the risks of nosocomial infections in clients/patients, visitors/attendants, contractors and staff.

No.	Measurable Criteria
12.1	The hospital establishes an infection control program designed to prevent or reduce the incidence of nosocomial infection, based on current scientific knowledge and accepted practice guidelines and developed and monitored with multidisciplinary involvement.
12.2	The infection control program includes all areas of the hospital and describes the scope, objectives, annual activities, surveillance methods, resources and processes associated with infection risks, including respiratory tract, urinary tract and surgical wound infections, are identified and included in the infection control program..
12.3	Responsibility for coordinating the infection control program is assigned to an infection control committee with representatives of all relevant disciplines and departments including medical, nursing, microbiology/pathology, kitchen and laundry staff.
12.4	The infection control committee has clear written Terms of Reference that include the following responsibilities: - Coordination of infection control activities - Development, implementation and monitoring of the infection control program - Approval of infection control policies and procedures - Approval of surveillance activities - Reviewing and analysing infection control data - Following up identified infection control issues with relevant action, including education - Evaluating the effectiveness of actions taken.
12.5	The infection control committee is linked with Waste Management Control
12.6	The infection control program is adequately resourced and staffed with appropriately qualified health professionals (nurses and/or doctors) with responsibilities defined in a job description for: - Implementing the infection control program in consultation with staff and clients/patients - Implementing policies - Educating staff - Providing infection control advice - Developing and implementing methods of surveillance, including reviewing infection control practices - Providing reports and making recommendations to the infection control committee.
12.7	Infection risks, rates and trends are tracked, analyzed and reported.
12.8	Surveillance of multiple resistant organisms and organisms associated with antimicrobial use is conducted as part of the infection control program.
12.9	There is evidence of regular infection control audit.
12.10	Cultures are obtained regularly from designated sites in the hospital with significant infection risks and action taken to minimise any identified infection.
12.11	Non-professional staff are appropriately inducted and trained in basic aspects of infection control relevant to their work including: - Basic concept of microbes - Proper handwashing - Segregation of waste and hazards associated with waste.
12.12	Professional staff are appropriately inducted and trained in all aspects of infection control

No.	Measurable Criteria
	relevant to their work, including proper handwashing.
12.13	Written and dated organisation wide infection control and waste management policies and procedures are used by staff. Procedures include, but are not limited to, the following topics: - Use of standard precautions including handwashing techniques - Sterilisation and decontamination of equipment - Food hygiene - Laundry and linen management - Identification and management of organisation-acquired infections - Management of outbreaks of infection - High risk and communicable diseases - Operation of the mortuary - Collection, storage and disposal of infectious waste, body fluids, tissues, blood and blood products - Disposal of sharps and needles - Cleaning of all hospital surfaces, supplies and equipment, e.g. floor, walls, ceilings, beds and basins - Management and cleaning of spillage - Vaccination of staff.
12.14	Gloves, gowns, masks, soap and disinfectants are available and correctly used in situations where there is a risk of infection.
12.15	All staff who work in client/patient related care and services have appropriate vaccinations and carrier status and records are kept.
12.16	Procedures are used for the isolation of patients specific to the reason for isolation.
12.17	There are procedures in place for identifying and treating patients admitted with MRSA (VRSA).
12.18	If an outbreak of MRSA is detected or suspected, a screening of all staff of that area is undertaken and acted upon.

13. STERILE SUPPLIES

Equipment and supplies are sterilised to minimise risk of infection in clients/patients and staff.

No.	Measurable Criteria
13.1	The Infection Control Committee oversees the provision of sterile supplies.
13.2	There is a defined department or area for sterilisation which physically separates the functions of cleaning, processing and sterile storage and distribution.
13.3	In all areas where instruments are cleaned there is airflow to prevent cross-contamination and to keep material within the area.
13.4	There is at least one functioning steriliser with a drying cycle.
13.5	The responsibilities of relevant staff members managing the provision of sterile supplies are clearly defined and specified in writing.
13.6	Staff responsible for the decontamination, inspection, function testing, assembly and packaging, terminal processing, storage and distribution of supplies are adequately trained.
13.7	Current written policies and procedures covering the functions of sterilisation, including the following, are available with documented evidence of routine compliance: - Receiving, cleaning and disinfection of used items - Preparation and processing of sterile packs - Storage of sterile supplies and expiry dates - Decontamination of instruments prior to sending for repair, maintenance or servicing - Handling of instruments following an infected case - Handling of equipment identified as “bio-hazard" - Product labelling, batch numbering and identification - Restricted personnel access to the clean production area - Cleaning procedures, manual methods - Housekeeping procedures - Infestation control - Personal hygiene - Microbiological and environmental monitoring - Criteria for testing and replacing air filters - Recall procedures.
13.8	Sterilisation procedures are based on existing provincial or national/international guidelines.
13.9	The sterilisation status of sterilised goods is assessed by the use of temperature sensitive tapes, using indicators as recommended by the manufacturer.
13.10	Reports of quality control tests on sterilisers are reported to the infection control committee at least quarterly.
13.11	The person using sterilised equipment checks that the decontamination of the equipment has been done before using that equipment.
13.12	Stock levels of sterilised goods are checked by an ongoing inventory management process.
13.13	Records are available for: - Acceptance of load procedures - Plant history records - Sterile goods issued to wards/departments - Sterilisers and autoclaves (history and servicing) - Servicing and calibration.
13.14	All trays/packs/containers are stored in conditions that preserve the integrity of their packaging to prevent damage and/or contamination.

No.	Measurable Criteria
13.15	All packs are marked with: - Name of the article - Contents of the pack - Initials of the person who packed it - Date and initials of the person who sterilised it.
13.16	Each tray, container or pack of instruments has a completed checklist which is used at the time of packing, at the time of use in the OT, and at the time of return of the instruments for re-sterilisation.

14. CLEANLINESS AND SANITATION

All hospital facilities, equipment and supplies are kept clean and safe for clients/patients, visitors/attendants and staff.

No.	Measurable Criteria
14.1	Staff follow written policies and procedures and schedules for: - Disinfection and cleaning of all equipment, furniture, floors, walls, storage areas and other surfaces and areas - Cleaning of specialised areas, e.g. OT, Labour Room, Emergency Ward, Dressing Room, Laboratory and ICU.
14.2	Hospital premises are free from litter and other refuse.
14.3	Sufficient covered, clean dustbins are provided for clients/patients, visitors/attendants and staff and the dustbins are emptied on a regular basis.
14.4	Equipment, floors and walls are free from bodily fluids, dust and grit and the masonry is intact.
14.5	Cleaners are trained and provided with sufficient appropriate equipment and cleaning material and work according to cleanliness and sanitation policies and procedures.
14.6	Laundry staff are trained and work according to linen and laundry policies and procedures including but not restricted to the following: - Collection of sluiced and dirty linen from the individual departments - Transportation with clear separation of clean and dirty laundry - Separate storage of clean and dirty linen - Sorting of linen into soiled, infected and foul linen and washing processes and washing processes for this linen - Removal of blood stains/sluicing - Disinfection/autoclaving - Washing / hydro extraction - Drying - Repairs of linen if required - Pressing - Distribution to individual departments - Storage in individual departments - Record keeping for receipt and distribution of clean linen.
14.7	Kitchen staff and/or those handling food are trained and work according to policies and procedures including but not limited to the following: - cleaning of all areas and surfaces on which food is stored and prepared, e.g. all preparation surfaces are cleaned and dried between uses for different activities - food storage, e.g. all food is stored separately from non-foods, cooked food is stored separately from uncooked/raw food and the covering and labelling of food - use and cleaning of equipment for food preparation, handling and transport, e.g. separate cutting boards are used for raw and cooked foods - testing and monitoring of safe temperatures for cooked food - testing and monitoring of refrigerator temperatures for safe food storage,
14.8	Access to the kitchen is restricted to staff members and a sign exists at all entrances stating this.
14.9	All staff handling food have health checks prior to appointment and at regular intervals during their employment and records are kept.
14.10	A written Dress Code for those working in the kitchen is enforced including wearing of head cover for hair, clean uniforms and appropriate footwear.
14.11	The kitchen and food stores have proper ventilation.

No.	Measurable Criteria
14.12	All windows in food preparation and storage areas have suitable fly screens and insectocutors (ultra-violet electric flying insect removers) are present in designated problem areas.
14.13	Kitchen walls are made of material that is waterproof, non-absorbent and non-toxic and kitchen floors, walls and ceilings are easily cleaned.
14.14	Kitchen waste is put in covered secure containers and removed immediately from places where food is prepared pending disposal.
14.15	Kitchens are arranged to be away from waste storage, ward areas, laboratories and other areas of risk of contamination and infection.

15. WASTE MANAGEMENT

Clinical and other infectious or injurious waste is handled, stored and disposed of to minimise harm and risk of infection /injury to patients/clients, visitors, contractors, staff and the community.

No.	Measurable Criteria
15.1	The hospital has a written waste disposal plan specifying procedures, responsibilities, timetable for waste collection and necessary equipment such as bins and bags.
15.2	The waste disposal plan includes written guidelines for the regulation, identification, containment and storage, transport, treatment and subsequent disposal of different categories of infectious waste, including if appropriate: - pathology waste - cytotoxic and chemical liquid waste) - heavy metals, radio-active or any other form of high-risk waste in accordance with the Pakistan Environmental Protection Act (PEPA), XXXIV of 1997.
15.3	Contaminated waste buried in land fills is done so in accordance with the Pakistan Environmental Protection Act (PEPA), XXXIV of 1997.
15.4	Infection control and waste management personnel use the Hospital Waste Management Rules 2005 in developing and coordinating plans, policies and procedures.
15.5	Suitably qualified and experienced person(s) with designated responsibility lead the development and regular updating of plans and policies and procedures for waste management and the process is overseen by the Infection Control Committee and infection control personnel.
15.6	Responsibilities for waste management are defined in all job descriptions.
15.7	All staff are trained in and use procedures for different types of waste: - Collection - Segregation at source - Storage - Transportation - Disposal.
15.8	All staff who work in areas where infectious waste is handled are trained on hazards of waste, management of waste and infection control.
15.9	Incineration facilities, where provided, are certified as conforming to health and safety and environmental health requirements by the Local Authority.
15.10	If contractors are used for the removal and incineration of clinical waste, a written contractual agreement and consignment procedure is used which includes identification of the origin, contents and quantity of the waste.
15.11	All waste is protected from theft, vandalism or scavenging by persons or animals.
15.12	A clear guide for waste segregation and storage is visibly posted in area(s) where this waste is generated and includes waste segregation in clearly labelled coded bins in accordance with the Pakistan Environmental Protection Act (PEPA), XXXIV of 1997.
15.13	Prior to collection and disposal, waste is kept in a suitable location which does not cause a hazard.
15.14	Records on the quantity of waste generation in each category of waste are maintained, analyzed and the resulting information is used for statistical and quality improvement activities by the Hospital.

PART E. SAFE AND APPROPRIATE ENVIRONMENT

16. HEALTH AND SAFETY

Promotion of health and safety and the avoidance of risk to human life as well as to the property of the Hospital are integrated within the organisation and among all levels of staff.

No.	Measurable Criteria
16.1	The responsibility for health and safety of hospital management and other relevant staff is included in their job descriptions and performance reviews.
16.2	A Health and Safety Committee meets on a regular basis, includes representatives of management and staff from different departments and enables two-way communication between management and employees on issues of interest and concern related to health and safety.
16.3	Health and Safety Committee meetings follow a set agenda that includes follow-up from the last meeting, minutes of each meeting are kept and the agendas and minutes are readily available to all staff.
16.4	The Health and Safety Committee participates in the development of the Risk Management Plan.
16.5	All new employees are trained in Health and Safety procedures relevant to their duties within one month of taking up their post.
16.6	All staff attend continuing training for health and safety and records are kept of the trainings
16.7	Each department uses a systematic process to: - Regularly identify and record actual and potential hazards in a hazard register (at lest annually) - Assess identified hazards to determine which are significant - Eliminate, isolate or minimise the impact of the significant hazards.
16.8	Staff review significant hazards that have been isolated or minimised in accordance with a set timetable appropriate for the identified hazards.
16.9	All emergency telephone numbers concerned with Health and Safety are displayed prominently.
16.10	Health and Safety policies and procedures are followed by staff and include: - Contamination incidents - Sharps and needle-stick injuries - Drug dependence - HIV/Aids - Hepatitis B and C - Lifting and manual handling of client/patients and equipment - Basic life support.
16.11	Organisation wide health and safety policies and procedures contain comprehensive information, instruction and safety protocols for: - Control of waterborne diseases - Storing and handling of inflammable liquid - Personal protective equipment and clothing - Review of pressure vessels and systems - Body fluid spillage - First aid procedures at work - Violence and aggression towards staff - Outbreak and prevention of fire - Other internal accidental events such as explosion - Safe use of electrical equipment - Safe disposal of clinical waste

No.	Measurable Criteria
	- Safe handling of gas cylinders - Safety precautions necessary when storing, handling and using liquefied gases, e.g. nitrogen and oxygen - Control and prevention of spillage of hazardous substances, like mercury and gluteraldehyde - Cytotoxic drugs - Introduction of new technology.
16.12	Current health and safety notices, including hazard notices, and key extracts from the Health and Safety manual are prominently displayed in relevant areas and brought to the attention of staff.
16.13	There is a procedure for ensuring that all contractors are provided with relevant information regarding health and safety issues within the hospital .
16.14	Staff sign a form that documents that they have read and understood Health and Safety policies and procedures.
16.15	A written policy and procedure on pest control including measures to prevent, detect and remove pests is available and implemented.
16.16	Security measures are taken in accordance with written policies and procedures to protect: - staff working alone or in isolation - clients/patients, visitors and staff from assault and loss of property during the day and at night - drugs from being taken illegally - the hospital's facilities and assets from damage and loss.
16.17	A procedure ensures that all hospital keys are available at all times to the staff on duty.
16.18	An internal communication system connecting all units of the hospital enables a continuous flow of communication and immediate reporting of any incident.

17. FIRE SAFETY AND EMERGENCY PREPAREDNESS

The organisation minimises the risks of fire and protects clients/patients, visitors and staff in case of fire and is prepared for disasters and emergencies

No.	Measurable Criteria
17.1	A fire safety plan exists including prevention/risk reduction, early detection, suppression, abatement, and safe exit from fire.
17.2	The hospital building, e.g. doors, exits and corridors, is constructed in a way to minimise the risk of fire and conform to fire safety rules, including: - Doorways, corridors, ramps and stairways being wide enough for the evacuation of non-ambulatory clients/patients - Fire and smoke doors being able to be opened and closed manually or by an electric release system - Doors to client/patient rooms and exit doors not being locked from the inside.
17.3	Access and exit ways are kept free of obstruction at all times to allow for safe evacuation in a fire or other emergency.
17.4	An annual inspection of fire safety in the Hospital by the Fire Department results in identification of fire risks and strategies to minimise the risks and prevent fire.
17.5	A person responsible for Hospital Safety carries out and records regular tests of alarm systems, fire extinguishers and other facilities and equipment for fire prevention and control.
17.6	Action is taken to address any recommendations made during inspections and testing.
17.7	A process ensures that furniture and furnishings are of limited flammability and toxicity and comply with approved safety standards.
17.8	All new hospital buildings above 15 metres have an alarm system complying with national standards (riser system, control panel and alarm); old hospital buildings above 15 metres should have at least manual call points or smoke/heat detectors/alarm system (1-2 per floor).
17.9	Pictograms indicating fire exits and escape routes are properly illuminated, clearly visible, unobstructed and are displayed at appropriate locations.
17.10	Potentially explosive, flammable or highly combustible material are clearly identified, securely stored and storage areas are clearly signed (Explosive Act).
17.11	Areas where smoking is dangerous, restricted and allowed are clearly signed and monitored.
17.12	Waste materials are stored in fire resistant containers.
17.13	Pillar and post type of hydrants are provided in new hospitals.
17.14	The electrical wiring in the Hospitals is changed every 20 years or when testing indicates.
17.15	Staff are trained at least annually in fire safety and other emergency procedures.
17.16	Fire procedures and evacuations are tested and disaster and emergency drills are practised regularly.
17.17	The Hospital develops a disaster plan with all departments/services. The plan is consistent with the Health Department's disaster plan and is reviewed and revised at least every two years.
17.18	The plan outlines individual responsibilities, linkages with external institutions, resources required in the case of a disaster and individuals within the hospital who must be informed in the case of a disaster.
17.19	Rehearsals of the disaster plan are carried out in association with the emergency services and local authorities in accordance with NWFP rules.

18. SAFE AND APPROPRIATE EQUIPMENT

There are clear and documented responsibilities, policies and procedures for procurement, use, maintenance, repair and disposal of equipment to minimise the potential for harm.

No.	Measurable Criteria
18.1	An Equipment Committee with clearly defined roles meets as required and includes those in charge of the hospital, nursing, maintenance and stores and other relevant departmental representatives.
18.2	Basic responsibilities of the Equipment Committee include: - Assessment of need for new equipment - Consultation with the requesting department on their requirements and specifications for the equipment - Procurement of equipment - Assessment of utilisation of equipment - Condemnation of equipment - Conducting regular equipment audits.
18.3	The procurement policy for equipment and supplies includes the criteria that equipment and supplies purchased are consistent in type and brand with others in the Hospital to facilitate maintenance and repair.
18.4	Placement of supply orders of equipment is done in accordance with the GFR (Government Financial Rules) and a copy of supply orders for equipment is kept in the Hospital records.
18.5	A written procedure is used for receiving ordered equipment and includes at least the following activities: - At time of delivery the equipment is inspected as per specifications given in the supply order by the equipment committee/user department. - On satisfactory receipt, installation and commissioning of the equipment a certificate to that effect is given by the equipment committee/user department. - Payment of the supplier is only made on production of such a certificate - Originals or a copy of the service contract and operational manual are kept in the maintenance department or other designated department.
18.6	Equipment is certified as conforming to health and safety requirements and regulations.
18.7	For costly equipment annual maintenance contracts are made including: - Regular service and maintenance for at least five years after the warranty period - Warranty with cost-free provision of spares - Continuous supply of consumables - Training of staff to handle the equipment - Reliable and prompt after-sale service - Penalty clause if any delay occurs due to the negligence of the supplier.
18.8	The suppliers contact details and emergency telephone number is available.
18.9	Staff allowed to operate equipment or machinery are appropriately trained and re-trained and no untrained person operates the equipment.
18.10	Records of equipment are kept including procurement, equipment defects and failures, maintenance, repair and disposal.
18.11	A maintenance workshop with qualified and experienced persons having basic knowledge of physics and electronics has defined responsibilities for maintenance and repair of smaller equipment.
18.12	The equipment maintenance staff are trained by the suppliers in the following issues: - Use and practice of equipment including proper handling of the equipment - Preventive maintenance and trouble shooting - Following the instruction manual in day-to-day use of the equipment

No.	Measurable Criteria
	- Common and recurrent causes of break-down - Common spare parts responsible for frequent break-downs - Inspection and routine maintenance - Calibration - Testing and safety guidelines - Technology up-gradation - Documentation of procedures for maintenance (SOPs).
18.13	A list of all electrical equipment that requires routine testing is used and a record of maintenance and testing of this equipment is kept for three years, e.g. generator, emergency lighting.
18.14	Regular and routine checks of equipment (equipment audit) are carried out in accordance with the operational manual, maintenance contract and/or a history sheet of the equipment by the Store in-charge.
18.15	Safeguards for electronic equipment are used such as: - Voltage stabilizer - Automatic switch over for emergency (generator).
18.16	For life-saving equipment a three-phased supply of electricity is provided.
18.17	A logbook for all critical equipment is kept and a record of incidence of defects and failures in equipment is maintained
18.18	There is a form known to all staff and used to request equipment repairs and defects.
18.19	An adequate and sufficiently large room and supplies are available for maintenance and minor repairs. Supplies include but are not limited to: - A bank of spare parts - Toolkit.
18.20	A list of maintenance/backlog items is kept and reviewed regularly.
18.21	Written procedures exist for - Requests for repair from outside agencies if equipment cannot be repaired in-house - Condemnation and disposal of obsolete equipment.
18.22	A list of approved external repair workshops is kept and regularly updated
18.23	All requests for repair, work carried out and response time to reported defects is monitored and documented.
18.24	The procedure for condemnation and disposal of obsolete equipment includes criteria for defining ‘condemned’ and ‘obsolete’ equipment, such as: - Non-functional and beyond economical repair - Non-functional and obsolete - Functional but obsolete - Functional but hazardous - Functional but no-longer required.
18.25	An annual budget is provided for the maintenance and scheduled replacement of equipment.

19. SAFE AND APPROPRIATE FACILITIES

The Hospital's physical environment contributes to the safety and well-being of clients/patients, staff and visitors.

No.	Measurable Criteria
19.1	The hospital complies with relevant laws and regulations related to design and layout of the facility and inspection requirements are fulfilled.
19.2	Corridors, storage areas, passageways and stairways are well lit.
19.3	Access ways and exits are unobstructed at all times.
19.4	Signage allows safe passage through the hospital and exit from the facility in case of an emergency, disaster or fire.
19.5	The environment in all client/patient areas is clean, well lit, ventilated with adjustable controls for lighting and heating, and decor is in good repair.
19.6	Floor surfaces are non-slip and even.
19.7	Facilities and equipment for the safety and comfort of clients/patients and visitors are available and functioning and include: - Refreshment facilities and canteen - Quiet rooms for consultations - A public telephone - Baby changing/feeding facilities - Wheel chair / stretcher - Defined and understandable signage system - Adequate Chairs - Cooling device, fans - Separate queues for male and females wherever required - Safe drinking water facilities - Sheltered outside areas with planting and greenery.
19.8	A functional call bell system is available for use in private and isolated wards (single occupancy rooms), within easy reach of the client/patient.
19.9	Each nursing area has a clean storage and preparation space and is separate from soiled materials, domestic equipment and sluice areas.
19.10	Separate male and female toilets and bathrooms are available and adequate for the number of clients/patients in the ward or department (at least one toilet for every twelve clients/patients). The toilets and bathrooms: - Are kept clean - Are lockable by the client/patient from the inside but unlockable from the outside - Have doors that open outwards - Ensure privacy at all times - Have a non-slip base - Have grab rails positioned on either side of the toilet - Have an alarm-call within easy reach of the bath and toilet.
19.11	Shower facilities are available, with warm water for winter months.
19.12	Separate male and female functioning, clean toilets are available for use by visitors/attendants.
19.13	Some toilets available to seriously ill or disabled clients/patients: - Allow a nurse to stand at each side to manoeuvre a client/patient - Admit a wheelchair - Have washbasins and a mirror at a suitable height for both able and disabled clients/patients.
19.14	Each client/patient has access to an area in which to keep personal possessions.
19.15	Bed tables are available.

No.	Measurable Criteria
19.16	Potable water and electrical power are available 24 hours a day, seven days a week.
19.17	Alternate sources of water and power for heat and lighting in case of breakdown of the systems are identified, functioning and regularly tested. Priority areas such as ICU and Operating Theatres are identified.
19.18	Electrical, water, ventilation, medical gas, and other key systems are regularly inspected, maintained and improved, if necessary.