CORE STANDARDS

A FRAMEWORK FOR THE ASSESSMENT OF HEALTH ESTABLISHMENTS

1. INTRODUCTION

During the past 13 years, many key interventions aimed at improving the efficiency, quality, safety of and access to care have been introduced.

A Patients' Rights Charter was launched, and packages of care with accompanying norms and standards for primary health care and district hospitals were formulated, supported by various clinical guidelines and a supervisory tool. The plan and the framework for the Modernisation of Tertiary Services were developed. A clinic-building programme and a hospital revitalisation programme were introduced with a built-in requirement for district plans and hospital improvement plans, based on an Integrated Health Planning Framework and including implicit standards for service delivery. National Policies on Quality in Health Care and on Infection Prevention & Control were developed to encourage an environment conducive to quality care and the development of the needed capacity.

In order to continue to strengthen these efforts to improve performance and quality of care, core national standards against which all establishments and services can benchmark themselves are needed. The gap between these standards and the actual level of compliance must be documented through a structured and nationally accepted measurement system - however a challenge has been to have an adequate tool to establish the evidence on what the real impact of many of our efforts has been.

Concerns with the quality and delivery of hospital services have been expressed in the media and other public forums with considerable frequency. Recent meetings and workshops have emphasised the need to address key challenges in the areas of infrastructure, staffing and quality of care. Taking the above into account, the Department of Health has initiated a process of measuring performance against a set of core standards. Having established this baseline, health facility improvement plans will be developed for those hospitals where performance has not been adequate. Other hospitals however will only need that their areas of good practice in relation to the core standards are identified and shared.

2. BACKGROUND and RATIONALE

2.1 Service challenges and initiatives

Challenges that have been identified through the national and provincial Complaints system, from surveillance and monitoring systems, and from reports from provincial health managers and staff as well as patients include:

- a lack of compliance with accepted guidelines or clinical practice
- instances of failures in technology
- outbreaks of nosocomial or hospital-acquired infection amongst neonates and in Intensive Care Units
- long queues and waiting times especially in Pharmacies and Outpatient Departments
- inadequate supervision of clinic staff
- lengthy turnaround times for laboratory tests especially for tuberculosis
- sub-optimal management systems and processes in many institutions

To address this situation, a number of Quality-related policies and strategies have been developed or are in the pipeline (the Quality Policy, Infection Control Policy and Strategy and a draft Clinical Audit Policy). Proposed quality-enhancing interventions already form part of the Hospital revitalisation Programme, the Hospital Improvement Plans discussed in 2005/6 and the District plans and information system. Some standards against which to

measure performance do exist and much effort has also gone into developing guidelines and manuals.

Similarly, efforts to improve management systems and skills are evident across the country and in the hospital and district systems. Training courses and plans for improvement have been focussed on an understanding of desired best practices and these are already evident in some areas.

2.2 Rationale for a common set of standards and a uniform baseline measurement

National standards are internationally recognised and used as a means of establishing expected minimum safety standards required across a health system as well as desired best practice.

In South Africa, while formal standards exist in some areas, in many other areas expected practice is expressed in broad policies and guidelines. The system is a complex one. Standards or guidelines are developed by more than twenty programmes and units at the national level and in many cases their efforts are mirrored or adapted at provincial and even municipal levels. Professional bodies and even private organisations also develop standards and guidelines. These contributions are made in different formats and with differing monitoring systems; making the task of performance assessment, benchmarking and implementing effective and integrated corrective action at delivery level very difficult.

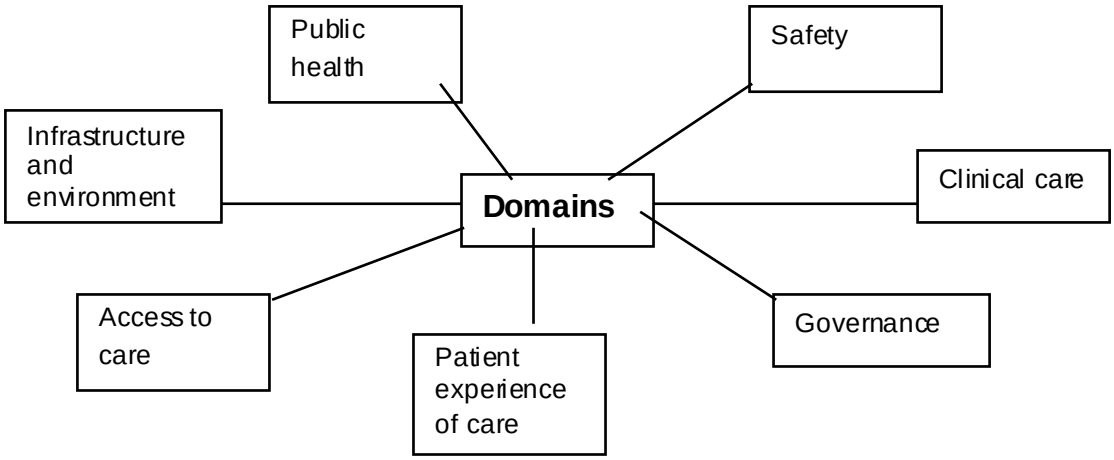
Roles and accountabilities for establishing levels of performance against standards are also not well-defined between the significant role-players. This is the case both within Departments, between different spheres of government, and between government and external bodies.

Under such circumstances, the availability of comparable and credible information on the achievement of a single set of national core standards becomes imperative; and is indeed reflected in the National Health Act (2003),

which states that “the Minister … may prescribe … a set of standards …” and “the Director General must issue, and promote adherence to, norms and standards….” Information regarding compliance with core standards would assist in making managers of hospitals and districts accountable for taking forward the proposed plans and improving delivery.

An appraisal will therefore be carried out of the performance of facilities against a set of core standards, which will benchmark them against a set of criteria to determine whether performance is good, adequate or poor. Starting with a small group of health facilities in the short term, this will provide, in a phased manner, an objective and comparable assessment. Areas of basic patient safety and dignity, and essential management activities, will be weighted in determining poor performance, as these will have the greatest impact on outcomes.

In order to facilitate dialogue and improve the development of these core national standards, a framework using 7 core “domains” aligned with hospital management areas has been used:



Within these, the critical areas for initiating the development of standards have been identified (see Section 5) and a set of core standards developed. This document outlines a process for a structured baseline assessment of selected

hospitals and CHCs to be conducted using initially a rapid appraisal methodology. The results will enable comparison between the various facilities and also within facilities over a period of time, and will be of immediate use in the development and implementation of improvement plans to close the identified gaps between actual performance and the standard. Some hospitals may have adequate or good performance in most areas and the appraisal would serve then to identify and share best practice.

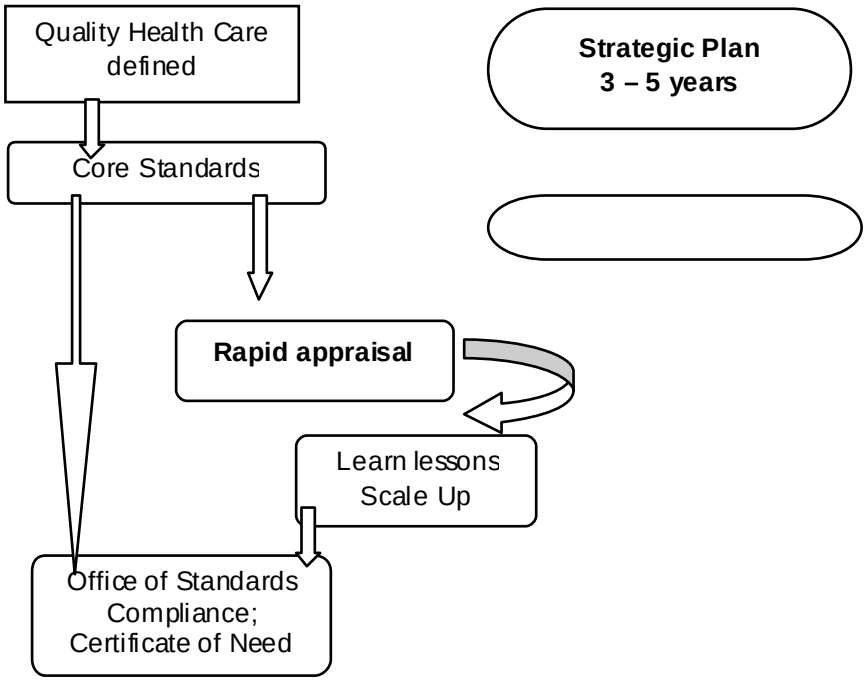
The reports will enable us to identify the following:

1. areas of weakness especially those pointing to potential risks to patient safety or basic human rights. Once action to correct these risks has been taken, close monitoring of performance against the standard will be needed.
2. areas which do not constitute an immediate high risk but can potentially evolve in this direction that will be identified for action and follow-up instituted
3. areas of good performance or best practice where standards are met and which can be used to benchmark performance

In identifying performance problems in specific areas, the process will also establish clearly whether this is within the competence of the facility manager to have resolved, or whether it reflects a system problem at a higher level. Improvement plans will also have to specify the higher level actions needed to address such issues and monitor that they are effectively addressed.

This is the first phase of a comprehensive national process as envisaged in the National Health Act that will over time widen the scope of the standards assessed and will progressively support all establishments. Core standards will be continuously monitored and improved as the process is scaled up and the methodology becomes entrenched.

CONTEXT FOR CORE STANDARDS



3. OBJECTIVES

1. To develop core national standards, criteria and indicators and the tools for their assessment in health establishments.
2. To establish a baseline in an initial set of hospitals and Community Health Centres to inform the development of Facility Improvement Plans
3. To review and evaluate the process and methodology for further developing the national core standards and mechanisms for their assessment.
4. To build on the lessons learned and expand the process to the next set of hospitals.

4. CORE STANDARDS

4.1 Domains and Action Areas

For the seven domains outlined in section 2.2, action areas have been identified for standards development:

Domain	Areas for core standards
1. Safety	1.1 Safe handling (and storage) of medicines 1.2 Patient safety system (reporting and information) 1.3 Infection Prevention & Control (incl. TB) 1.4 Medical device risk reduction
2. Clinical care	2.1 Clinical governance 2.2 Use of guidelines and protocols 2.3 Diagnostic services (laboratories & X-Ray) 2.4 Clinical audit and reviews 2.5 Appropriate use of technology 2.6 Delivery of an appropriate package of services 2.7 Medical records
3. Governance	3.1 Management and planning 3.2 Financial management 3.3 Procurement 3.4 Human resource management 3.5 Information and management 3.6 Corporate Governance 3.7 Quality Improvement Programme 3.8 Risk management 3.9 Research governance 3.10 Communication and public relations
4. Patient experience of care	4.1 Patient rights / Patient health charter 4.2 Complaints System 4.3 Help desk / hospital information 4.3 Patient perceptions of care
5. Access to care	5.1 Timely access to care 5.2 Access to medicines 5.3 Referral system 5.4 Ambulance response and turnaround time 5.5 Emergency care treatment 5.6 Physical access
6. Infrastructure and environment /	6.1 Cleanliness and litter 6.2 Medical waste management 6.3 Equipment 6.4 Hotel services (laundry, catering, linen and clothing, utilities). 6.5 Safe and secure environment 6.6 Design and condition of buildings for safe delivery of care
7. Public health	7.1 Health promotion and prevention programmes 7.2 Integration of care including community involvement 7.3 Disaster or outbreak preparedness and response

4.2. Standards, Criteria and Indicators

"A **Standard** is a quality, or qualities, which serve as a basis to which others conform or by which the quality of others is judged; the degree of excellence required for a particular purpose." (Canadian Oxford dictionary)

"A **Criterion** is a rule or test on which a judgement or decision regarding the achievement of a standard can be assessed."

A common format has been used for each domain and action area, making clear the definitions used and the intent of the set of standards; and then capturing the standards, criteria and indicators in a tabular form (see Standards and Criteria in annexure). Given that this is an initial rapid appraisal and not part of a full accreditation exercise, the standards have been defined at the level of an institution or of selected units within it. They are not intended at this stage to cover the detailed review of all clinical departments. In choosing the most critical areas to include in this appraisal, the degree of public interest, the impact on hospital health status outcomes, the feasibility and cost of a corrective response and the impact on the broader turnaround strategy were considered.

Existing polices, guidelines and plans have been used to formulate the standards in order to ensure that establishments are being measured against legitimate expectations (see Bibliography). The standards reflect expected best practice from a health system strengthening perspective, as well as essential facility-level actions defined from a health programme perspective.

6. APPRAISAL

The standards express an expected level of performance as evidenced or specified by the criteria. The degree to which the criteria are or are not met will be established by means of a questionnaire. This questionnaire will use a

combination of indicators (data already captured through the National Indicator set and DHIS) and a checklist reflecting the degree of implementation or compliance.

The initial group of 28 hospitals and 4 CHCs has been chosen to include a range of institutions at different levels of care in different provinces. The appraisal exercise by the management of each facility, covering the degree to which they meet the criteria as specified in the checklist, and their performance in terms of key relevant indicators in the National indicator data set. This will be followed by an on-site visit by an appraisal team, which will verify the results of the self-appraisal and report back to hospital management as well as the Facility Improvement plan support team.

The appraisal teams will be drawn largely from the National and Provincial Departments of Health and will include both clinical and management experts. Comparability and validity of results will be strengthened through an initial training programme as well as on-site and remote monitoring during each visit.

7. COMMUNICATION

The purpose and outcomes will be continuously communicated through both written and face-to-face interactions with all relevant stakeholders (internal and external) involved in this Rapid Appraisal exercise as well as the subsequent Health Facility Improvement process.

Situations requiring immediate attention should of course be identified and urgent measures to correct them taken as part of the expected responsibilities of the managers concerned, at all levels of the system.

However, of equal importance will be identifying the many instances of good practice. Through this review, instances of excellent or acceptable performance will be documented as often as those of poor practice – and all of these may be found in a single institution. The review will enable such

practices to be recognised and will also contribute to a process of benchmarking these for emulation by other institutions over time.

The most critical communication objective is that staff will feel encouraged and assisted by the process. Such an attitude will be one of the most critical success factors in ensuring that performance is indeed improved.

8. EVALUATION

The standards, the methodology and the results will be reviewed through an external evaluation concluded within 3 months after the initial appraisals.

The evaluation will examine the formulation of the standards and criteria, the scope of the domains, action areas and standards, the selection of the indicators and their interpretation, the design of the checklist and its use in both pre-appraisal and verification, the functioning of the teams and the quality of the reports and their the usefulness for the development of the Improvement plans.

This evaluation will significantly enhance the contribution to refining the national core standards and will also assist in planning for the scale-up of the appraisals to cover other establishments.

CORE STANDARDS AND CRITERIA

Definition: Patient safety includes initiative to identify, report, analyze and prevent any unintended or unexpected incidents that could harm health care users.

Intent: To minimise risk and improve patients' safety through reporting, analysi s prevention of medical errors and adverse events.

Action areas in this domain:

1.1	Safe handling and storage of medicines.
1.2	Patient safety systems (reporting and information).
1.3	Infection Prevention and Control (Including TB).
1.4	Medical device risk reduction.

Area	Organisational standard	Criteria
1.1 Safe handling and storage of medicines	Medicines are appropriately stored and packaged to ensure that the medicine is not inactivated due to light, temperature etc.	A fridge and freezer is available and functional
		Temperature in the storage area is maintained at room temp.
		The storage area is suitably secured and protected against unauthorised entry or atmospheric pollution
		Appropriate packaging is ensured for various pharmaceutical dosage forms ie tablets and liquids
	Suitably qualified staff handle medicines and supply them to other healthcare professionals	There are sufficient pharmacists and pharmacy assistants to cover the prescription workload
		Pharmacy assistants are supervised by pharmacists
		Standard operating procedures exist for the safe handling of medicines for inpatients and out-patients

Area	Organisational standard	Criteria
1.2 Patient safety system (information and reporting)	All steps are taken to ensure the safety of care and the environment through the ongoing assessment and management of risks	The facility conducts risk assessments for safety risks inherent in its patient population.
	Local patient safety education needs are met	Area specific patient safety Information is available.
		Patients are encouraged to be actively involved in their own care as a patient safety strategy.
		A system is in place to communicate the means for patients and their families to report concerns about safety.
		All staff wear formal name tags to enable identification at all times
	Adverse events or incidents are actively monitored and managed	An adverse events management committee is in place.
		The facility conducts risk assessment for adverse events likely to occur.
		There are incident management processes & procedures in place.
		Reported adverse incidents are investigated and recommendations are implemented.
1.3 Infection Prevention and Control (including TB)	The risk of health care associated infections is reduced through ongoing monitoring and management	The National Infection Prevention and Control Policy is available.
		Provincial and local IPC guidelines and protocols are available and implemented.
		There is an appropriately trained Infection Prevention and Control Officer.
		An IPC committee is in place in the facility.
		There is a costed and budgeted IPC plan and regular progress reports.
		Infection surveillance data is routinely collected, analyzed and used
		Nosocomial infection outbreaks are investigated and reported.
		Protective clothing for staff and patients is available and used when needed
		Ongoing hand hygiene improvement interventions in place.
	The facility actively	The facility has policies and protocols in

Area	Organisational standard	Criteria
	manages the infection prevention and control of TB	place for the management of TB IPC.
		The facility implements measures to reduce concentration of TB bacilli in air in areas where contamination of air is likely.
		A (respiratory protection) program for TB is in place to empower patients and staff to take appropriate precautions to prevent TB infection.
		There is a system in place to facilitate early identification and isolation of confirmed and suspected cases.
1.4 Medical device risk reduction -	Hazardous substances are managed and controlled	All medical devices are registered / licensed in accordance with the Hazardous Substances Act (excluding medical instruments and medical disposable items)
	Safe usage of medical devices is ensured through adequate usage, storage and maintenance	All medical device Users are trained and supported in correct, optimal utilisation and safe storage of the available medical devices and meet legal or licensing requirements (for medical X-Ray equipment)
		All medical devices to be serviced, calibrated and maintained in accordance with the Manufacturer's conditions as well as the licence conditions for medical X-Ray equipment
		There is an Institutional Policy regarding the decontamination of all medical devices
		Health Technology Adverse Event Reporting and Management Policy is available to ensure correct incident reporting, immediate removal of defective device(s) and bagging of disposable items
		Access to ECRI information (immediate international medical device recall) is available and a responsible person is appointed to perform this action
		Safety Gear, to protect patients and staff, is available and functional within the room where the medical device will be utilised (e.g. lead aprons, gonad shields)

DOMAIN 2: CLINICAL CARE

Definition: Clinical care covers the provision of the inputs and guidance needed for the direct provision of patient care by clinicians and the mechanisms to ensure that care is effective and responsive.

Intention: The intention is to ensure that all the requirements for patient care are in place and the appropriate skills are available to deliver clinical care.

Action areas in this domain:

2.1	Clinical governance.
2.2	Compliance with guidelines and protocols
2.3	Clinical support services
2.4	Clinical Audit and reviews.
2.5	Appropriate use of technology.
2.6	Delivery of an appropriate package of services
2.7	Medical records

Area	Organizational Standard	Criteria
2.1 Clinical governance	1. Clinical leadership is accountable for the delivery of quality health care that meets patient needs within the available resources	The facility organisational structure reflects the key Clinical departments (patient care; support services)
		Senior clinicians are designated as Heads of Departments or sections with clear written accountabilities and authority
		An individual with appropriate training, education, and experience directs each department or service in the organisation.
		Heads of Departments / senior clinicians plan and organize their services to ensure the best use of available resources (staff, consumables, equipment)
	2. Delivery of best-practice clinical care and the	Senior clinicians / clinical managers lead by example in implementation of best-practice guidelines

Area	Organizational Standard	Criteria
	continuous improvement of services is enhanced through sound clinical governance practices	Procedures exist to identify, act on and learn from all patient safety incidents and other reportable incidents
		Clinical practice strives to find better ways of working through an analysis of results and outcomes
2.2 Compliance with guidelines and protocols	National and provincial guidelines and protocols guide diagnosis, treatment and care	The Essential Drugs List (EDL) and Standard Treatment Guidelines for the relevant level of facility is available and utilised
		Treatment protocols follow national and provincial guidelines
2.3 Clinical support services	Diagnostic laboratory services are accessible and effective	Laboratory services are provided on-site or through a referral service
		The range of services provided is appropriate to the specified level of care
		The turnaround time for results is within specified limits
		The quality of the results is perceived by clinicians and management to be acceptable
	Appropriate Radiology services are available	Medical X-Ray equipment is available and functional for the specified level of care
	Other clinical support services are available in accordance with the level of care	Blood is available as required and in accordance with the specified level of care
		Rehabilitation services are available in accordance with the specified level of care
		Social support services are available in accordance with the specified level of care
	1. Processes to improve clinical quality are in place.	Policy directives and guidelines for Clinical audit are available in all service areas.
		Each service area conducts regular clinical audits
		Mortality and morbidity reviews are conducted regularly.
		The facility has a functional Quality Assurance / Clinical Audit Committee.

Area	Organizational Standard	Criteria
		Recommended quality improvement activities are implemented.
		Staffing of clinical departments meets basic levels required for safe clinical care as per provincial or national benchmarks
2.5 Appropriate use of technology	Appropriate medical devices available in each clinical service area	Medical Device Risk Policy available in each Clinical Service area indicating the minimum devices and quantities to be available at any given time
		Regional and Central Hospitals: Critical items available in: - Trauma and Emergency - Diagnostic radiology - Anaesthesia - Theatre and Recovery room - Maternity - Paediatrics / Neonatal unit - ICU and Critical care - Internal medicine - O&G / Urology
		District Hospitals: - Critical items available in: - Trauma and Emergency - Diagnostic radiology - Anaesthesia - Theatre and Recovery room - Maternity - Baby room (neonates)
2.6 Delivery of an appropriate package of services	• The facility delivers a defined range of health services based on its stipulated level(s) of care.	The facility delivers the approved range of services
		For the defined package of services, the facility meets national or provincial benchmarks for: - Infrastructure - staffing - equipment - outputs
		A system exists to monitor inappropriate provision of care (at a level below that specified)

Area	Organizational Standard	Criteria
		Measures are in place to reduce inappropriate care
2.7 Medical records	• Medical records are created, maintained and stored to standards which meet legal, regulatory and professional requirements	There is a Records management policy in place (which complies with the Archives act)
		All Admissions, Discharges and Transfers have a standard Medical Discharge Summary completed
		All Medical Records at the facility include as a minimum a Problem List and follow the SOAP (subjective objective assessment and plan) structure
	• An Electronic Patient Information System is deployed to enhance the Quality of Care	A Facility Master Patient Index is available on-line
		The Core Modules are deployed: - Patient Registration, - The Minimum of a medical Record, - Clinical Pharmacy, - Appointment Scheduling - Billing

DOMAIN 3: GOVERNANCE

Definition: **Governance** is the use of structures of authority and collaboration to allocate, coordinate and control resources in the health department

Intent: To indicate the health care structures and their responsibilities towards ensuring that facility's operations in providing quality health care are realised

Action areas in this domain:

3.1 Management and planning
3.2 Financial and resource management
3.3 Procurement
3.4 Human resources
3.5 Information and management
3.6 Corporate Governance
3.7 Quality Improvement
3.8 Risk management
3.9 Research governance
3.10 Marketing and communication

Area	Standards	Criteria
3.1 Management and planning	Managers develop and monitor comprehensive strategic and business plans	Up-to-date annual strategic and business plans exist using standardised formats that include new services or other change processes
		Plans are driven by service need and/or expectation for all service areas
		The plans and budgets reflect provincial and national priorities as well as internal and external issues / needs
		Human resource and financial planning are directly linked to the strategic and business plans for each unit so as to integrate need, activities and resources
		Health Technology / medical devices are planned and the capital and costs of ownership budgeted for, including adequate monitoring, maintenance and repair
		Managers have received training or briefings on strategic and business planning and on key legislation (PFMA)
		Hospital management prepares regular reports according to format for discussion with the province, covering performance, progress and variances
	There is a direct link between business and financial planning, performance management and management infrastructure	Accountability and responsibility are clear through plans, management frameworks and organisational structures
		Organisational structures reflect service objectives
		there is clear devolution and expectation of management duties and departmental heads can be held accountable for management performance

Area	Standards	Criteria
3.2: Financial management	Appropriate tools, information and skills are available to enable management of expenditure	managers can access and analyse information on expenditure (actual and committed) against budgeted costs on a monthly basis
		cost centres are in place to ensure that managers have financial information to monitor performance
		Heads of Department monitor variances on actual expenditure to budget and report monthly on variance and their response to this
		managers understand and assess cost-effectiveness relationships (consequences of activities, anticipate activity changes to financial performance)
		senior management monitors overall expenditure (actual and committed) on a monthly basis and holds managers accountable
	Resources are adequately managed and efficiency savings are achieved	efficiency targets and anticipated savings are set within the business plan or during the year based on performance and regularly monitored
		these plans are communicated to all staff members
		medical devices are monitored in order to maximise up-time and utilisation through proper management, scheduled maintenance and accurately forecasting replacement needs
	Adequate control processes are in place for the charging of services (Road accidents, WCA, private patients)	a daily census is performed on all new patients and discharges
		inventory counts are performed on a daily basis to reconcile ward inventories with patient issues and investigate variance
		there are defined procedures for collection of these debts
	Appropriate controls exist for cash receipts	there are clearly developed processes and procedures for the control of cash
3.3 Procurement and supplies	Selection processes for	users of supplies are involved in discussions on new products and processes, including training needs, and their input documented

Area	Standards	Criteria
	equipment and consumables are efficient and transparent and reflect the needs of both users and management	A process exists for prioritising the procurement of appropriate medical equipment (facilities, personnel and budget available)
		Clear processes and procedures govern selection including a functional assessment and option analysis where appropriate
		Effective procedures exist to limit and/or to monitor influences on purchasing decisions (e.g. medical reps)
	Stock and equipment is managed effectively and efficiently to maximise use, maintain adequate levels and reduce losses	Information systems to manage stock are in place and functional
		An asset register of medical equipment is available and updated regularly
		Medical repair maintenance records are kept (costs, dates, etc.)
		Usage of critical items is analysed for each department / ward and reasons for variance identified
		Risks due to loss or theft are identified and managed
		Clinical engineering technicians are employed for repair and maintenance of equipment OR maintenance contracts / agreements are in place for critical medical equipment
		Parts and disposables for equipment are available on-site or in a reasonable time
		Mechanisms are found to ensure maximum use out of high cost items (e.g. sharing)
	Procurement policies are in place to ensure adequate stock of the appropriate medicines for the specified level of care	A standard operating procedure guides the ordering of medicines from provincial depots, including standard stock levels.
		Sufficient budgetary provision is made for planned medicine usage
		No stock outs on medicines are documented at the facility.
	Adequate management control of procurement process exists	Senior management assess the procurement system and ensure maximum value-for-money
		The procurement section has adequate staffing and sufficiently senior management to meet performance targets

Area	Standards	Criteria
		Goods are paid within the required time frame and discounts for prompt payment are received
3.4 Human resource management	A human resource plan forms part of the Strategic and Business plans and monitoring system	Suitable approved organograms in accordance with the specified level of care and service package exist to guide staffing and roles
		These are fully funded in the business plans and approved budget
		Vacancy rates (of funded posts) are documented and regularly reviewed
		Vacant posts are timeously advertised and filled
	Authority is delegated to appropriate levels to improve efficiency	Delegations from the Provincial office to Facility managers / CEOs exist and follow national guidelines
		Delegations to Heads of Department and unit managers exist and follow provincial guidelines
	Performance is regularly reviewed against agreed outputs	A system exists for establishing staff responsibilities and outputs for each year
		Managers at all levels regularly review staff performance against these and either commend good performance or take measures to improve poor performance
	Duty planning and management of staff adequately covers duty rosters, overtime, leave, contracting of additional staff	Clinical protocols, Quality control and outcome measures are used to guide the organisation of services and to monitor performance
		Acuity levels, patient flow, bed occupation and activity levels are used to plan duty rosters for efficient use of staff
		Departmental Heads determine planning flexibility and conduct regular reviews of staff utilisation
		All overtime or contracting of additional staff is approved by the Departmental head in accordance with the budget and duty plan
		Time sheets are completed and signed off by the HoD for specified staff
		Leave, sick leave and absenteeism are actively controlled and monitored by the Head of Department and the Personnel dept

Area	Standards	Criteria
		Ongoing monitoring and control as well as regular audits or reviews are conducted of the planning and controls for staff time use including doctors
	An efficient system exists to implement Disciplinary controls	all staff and supervisors have received training and regular updates on LR policies
		management receive cooperation and guidance from LR officers and advisory committees
		adequate record keeping at all levels to support procedures is prioritised
		cases are recorded and outstanding cases followed up (with Head Office)
3.5: Information and manage-ment	The Minimum Data set at the facility meets the agreed NHIS/SA requirements for Quality and Timeliness	Usage by management of the core elements and indicators is evident
		Data Quality and Data Flow Policy are available
	All Transversal systems are available and functioning according to protocols	The facility is able to use Persal, BAS and Logis on-line
		The Pharmaceutical system (remote demanders module) is available online
	Information and Communication Technology (ICT) and software required for Management and Patient Care is well managed	An inventory of ICT's required for Management and Patient Care is available
		- Telephones, Faxes, Computers, Pagers and other communications tools (including networks)are recorded in the asset register
		- All software used in the facility is recorded in the "Systems Availability" register
		- Functional Systems include: BAS, Logis, Persal and DHIS
	Information Management is supported by a dedicated staff complement	The organogram has dedicated staff for Information Management
		A Facility Information Officer and Ward Clerks are appointed
		- Facility data is collected and collated by dedicated staff

Area	Standards	Criteria
3.6: Corporate Governance	Hospital boards are appointed and functional	Properly appointed hospital board with set number of meetings
	Hospital boards are trained on a standard manual	The manual sets out the objectives according to the NH act.
	Corporate governance manual on Fraud and transparency	Manual to set out the acceptable business practices
3.7 Quality Improvement Programme	The facility's clinical and managerial leaders collaborate in planning and actively implementing a quality management and improvement programme	There is a written plan for an organisation-wide quality management and improvement (QA) programme covering key areas
		There is a dedicated QA Committee that designs and oversees the programme
		Medical, nursing and general managers are familiar with the concepts and methods of Quality Assurance.
		Medical, nursing and general managers participate in relevant QA processes:
		Managers ensure that Quality Improvement teams are established and functional in all areas of the facility
	Staff members actively participate in the QA activities of the organisation-wide programme.	A training programme equips staff with the necessary skills and competencies
		Staff participate actively in the quality improvement teams.
3.8 Risk Management	Management has an established process for identification, assessment and intervention in relation to risks across the institution	An integrated risk management strategy is available
		Risk management functions are integrated into employees job descriptions
		Risk management activities are included in the Strategic and Business plans
		Controls and procedures in place for key risks are regularly evaluated and constraints identified
		Operating policies and procedures in all services guide implementation
3.9: Research governance	Any research conducted in the facility is carried out with appropriate	There are written procedures that set out the requirements to be met by research projects
		All Clinical research projects have Ethics Committee approval

Area	Standards	Criteria
	consent and authorisation from the subject and in line with guidelines on research projects.	All Clinical research projects follow the DOH guidelines
		Lawful consent or authorisation is obtained form all subjects / participants and kept on file
3.10 Communication and public relations	The facility has a communications strategy and plan supported by top management to address internal and external and relations with stakeholders	The strategy and plan cover both internal and external audiences
		An understanding of the communication needs of different stakeholders is reflected in the strategy and plan
		There are clear procedures relating to dealing with the media

DOMAIN 4: PATIENT EXPERIENCE OF CARE

Definition: The patient experience of care encompasses initiatives aimed at assessing, ensuring and improving health care users' levels of satisfaction or perceptions of care after using the health care service.

Intent: To identify and as far as possible address the gap between the expected service and the experience of the service, from the client/patient's point of view.

Action areas in this domain:

4.1	Patients' Rights/ Patients' Rights Charter
4.2	Complaints System.
4.3	Help desk/ hospital information.
4.4	Patients' perception of care

Area	Organisational standard	Criteria
4.1 Patient rights / Patient health charter	The Patient's Rights Charter is used to protect and promote the Implementation of patients' rights	The Patient's Rights Charter is accessible and visible for all users of the facility
		The hospital ensures that patients have access to information on their rights
4.2	There is a complaints management system in place	There is an identifiable Complaints Manager.

Complaints system		A clear and accessible Complaints' procedure guides patients, families and the community on how to make complaints (in accordance with national guidelines)
		Complaints are handled according to the facility's complaints procedure (in accordance with national guidelines)
		The facility has a complaints register.
		Investigation / analysis of complaints leads to appropriate preventive action by Management
4.3 Help desk / patient information	• Patients have access to information on hospital services and processes	There is an accessible and visible help / information desk
		Availability, location and times of Services are publicly displayed
		There is legible and understandable signage directing patient or visitors to key areas of the facility
4.4 Patients perception of care	• There is a system in place to measure patient / client perception of care	Client satisfaction surveys are conducted and analyzed.
		The facility implements quality improvement initiatives based on the recommendations of the survey reports.

DOMAIN 5: ACCESS TO CARE

Definition: Access to care covers the initiatives aimed at ensuring that patients have access to appropriate services within a reasonable period of time at the facility at which they present or through a well-functioning referral system for both acute and chronic cases

Intent: To ensure that the patient receives the needed treatment, care and support in an equitable and timely manner

Action areas in this domain**:**

5.1. Timely access (queues, waiting times in OPD & Casualty).
5.2. Access to medicines (stock-outs; queues in Pharmacies).
5.3 Referral system
5.4. Ambulance response and turnaround time.
5.5 Emergency care treatment
5.6 Physical access

Area	Organisational standard	Criteria
5.1 Timely access	Patients have access on arrival to correct information on the services offered at that service point	Information is available on the services being provided and on the referral processes.
	Patients are attended to within and acceptable period of time and in accordance with their needs	Waiting times in key areas are monitored and measures taken by management to address causes of blockages
		A maximum waiting time is locally determined per service area
		Screening is initiated at the point of patient entry into the hospital.
		Effective mechanisms exist to ensure seriously ill patients are immediately attended to
		Policies & procedures address the management of patients when there is no vacant bed in the facility.
		There are Fast Lane queues e.g. for chronic medication
5.2 Access to medicines	Appropriate Medicines are available as prescribed.	Medicines as per the relevant EDL are available 90% of the time
	Patients can obtain their medicines from the pharmacy or provider within an acceptable period of time	There is a locally-determined maximum waiting time for acute and chronic patients
		Patients do not usually wait longer than the specified acceptable waiting time
5.3 Referral system	A defined referral network and system guides clinicians at all levels when referring patients or sharing care across different levels	There is an up-to-date list, map and contact numbers of facilities and community-based institutions that receive patients being referred for specified services according to provincial / local guidelines

Area	Organisational standard	Criteria
		Clinicians and staff in all service areas use this list for referrals (or discharges) among all levels of care, and to ensure continuity of care for chronic illness
		Procedures exist and are implemented regarding the clinical responsibility and documentary requirements for lower levels referring to a higher level, for both acute and chronic cases
		Procedures exist and are implemented regarding the clinical responsibility and documentary requirements for higher levels referring an acute or chronic patient to or back to lower levels:
	An efficient system enables the movement of patients between different levels of care	The Planned patient transport system is adequately resourced to transport non-emergency patients being referred
		Criteria and procedures guide the call-out of Emergency Medical transport
		A reliable communication system e.g. telephone, radiophone or cellular phone is available to ensure speedy referrals
	PHC facilities are staffed and equipped to treat and manage patients appropriately	Staff are adequately trained to manage patients in line with their scope of practice
		Staffing levels meet provincial minimum benchmarks / norms for the specified level of care / service package
		Essential equipment is available for the treatment of patients at that level of care
		Essential drugs are available for the treatment of patients at that level of care, including specific drugs for down-referred patients
		Patients are educated about the levels of care and the services available to strengthen use of the referral system and continuum of care

Area	Organisational standard	Criteria
5.4 - Ambulance response and turnaround time	Admission / discharge / transfer of emergency cases handled efficiently and competently by hospital staff	An emergency admission / discharge / referral policy and procedures exist
		adequate admission staff and systems enable the establishment to comply with established procedures
		For receiving hospitals: clinical records documents exact arrival and handover times (hospital clinician)
		Management of Casualty regularly analyses handover times in order to improve them
		For transferring hospitals: all clinical information, the identification of the referring and receiving doctors, and the ambulance call-out and hospital departure times are documented and a copy given to the ambulance crew
	Hospital closures and ambulance diversions managed so as to reduce impact on patient care and ambulance services	Level 1 Trauma centres accept critical patients for stabilisation irrespective of closure status (as long as the ambulance waits for the patient)
		All requests for closures to be made only after on-site attempts to avert closure have been carried out by the medical superintendent and documented in writing to the relevant coordinating authority
	On ambulance call-out for transfers and referrals, establishments provide adequate clinical information to guide despatch of an appropriate level of emergency care	clinical records indicate the level of assistance requested form the ambulance service
		Handover notes reflect the level of assistance requested and that received
5.5 Emergency care treatment	Patients requiring emergency care are never refused care and are always stabilised before referral	The facility has procedures to ensure that no patient requiring emergency care is ever turned away without being examined
		Emergency cases requiring referral are always stabilised first within the limits of the facility' capacity

Area	Organisational standard	Criteria
5.6 Physical access	The facility offers safe and easy access and entry by patients	The facility is readily accessible from - a National, Provincial or municipal tarred road - a passenger rail network - a bus route - a taxi route
		The entrance to the facility facilitates easy and safe entry by the public
	The facility enables persons with disability to access critical areas and services	The entrance into the facility is level or there is a ramp with handrails to allow access to persons with reduced mobility functioning
		Assisted access is provided from the point of public transport with respect to distance and terrain
		There is clear signage for persons with visual impairment
		Critical points in the facility are designed and equipped to enable persons with disabilities to make use of the services and amenities
		There is at least one staff member who can use / interpret sign language

DOMAIN 6: INFRASTRUCTURE AND ENVIRONMENT

Definition: The facilities, environment and infrastructure should ensure an acceptable, appropriate, hygienic and safe environment for health care users and health care users

Intent: To ensure that key support services, buildings and equipment are appropriate, available and safe

Action areas in this domain:

6.1 Cleanliness and litter
6.2 Medical waste management
6.3 Basic equipment and services
6.4 Hotel services (laundry, catering, linen and clothing)
6.5 Safe and secure environment
6.6 Design and condition of buildings

Area	Organisational standard	Criteria
6.1 Cleanliness & litter	The cleaning service is effectively managed to ensure a clean and safe environment	A person who is suitably experienced manages the cleaning service.
		Standard operating protocols for cleaning are in place.
		Training needs of house-keeping staff are identified and addressed
		Cleaning materials are available and properly stored.
		Minimum –maximum stock levels are maintained.
	The public perceive / experience and participate actively in maintaining a clean and hygienic environment	Public and sensitive areas are kept in a hygienic state
		A program is in place for the education of patients on environmental hygiene
6.2 Medical Waste management	Medical waste is managed to reduce potential risks to patients, staff and the public	There is a dedicated medical waste manager
		There is a facility medical waste management plan.
		All categories of staff are provided with in-service training on their role in medical waste management.
		Policies and procedures for management of accidental exposure to medical wastes and blood borne pathogens are in place.
		There is behaviour change communication material relevant to medical waste management.
		Medical Waste is segregated in accordance with the waste management policy
		Waste is protected from theft, vandalism or scavenging.
6.3 Basic equipment and services.	Basic services and equipment are available and functional	All basic services are readily available e.g. power, emergency power, UPS, medical gas, scavenging, steam, air conditioning, extraction, warm and cold water All devices and services are appropriately placed and reachable A Health Technology Decommissioning and Disposal policy is in place

Area	Organisational standard	Criteria
6.4 Hotel services (laundry, catering, linen and clothing)	Laundry and linen is managed to ensure a safe and acceptable service.	A suitably trained and experienced person manages the service.
		All newly appointed staff members providing the service are orientated through an induction course and receive continuous in-service training.
		Procedures and processes are available in terms of - the separation of staff working in the soiled and clean areas within a facility - how to handle infected linen - searching used linen for sharps. - the delivery of clean linen - providing clean clothing to patients
	Minimum standards for food provisioning as stipulated in the National Food Service Management Policy are followed.	Menu cycle of 8 – 21 days available to ensure variety of menu items.
		Database of standardised recipes available to ensure correct meal preparation.
		Ration Scales used for the planning of meals and procurement of food items.
		Serving meal times are clearly defined and adhered to. There is not a time difference of 12 hours between supper and breakfast.
		Meals are delivered (distributed) to wards using appropriate trolleys and at the correct temperature. Food is delivered within 20 minutes of being dished up in the Food service Unit.
		Food waste studies are conducted whenever a new menu is introduced to measure acceptability.
	The Food Service Unit is efficiently and effectively managed.	The facility has a qualified Food Service Manager (FSM) if there are more than 100 beds.
		Food service personnel receive continuous training to improve their skills.
		Cost control measures that consider procurement procedures, # of clients served / day, food production, meal portioning, inventory management, and meals served to employees, are in place.

Area	Organisational standard	Criteria
		A standardised monitoring tool is used to do quality control in food health services.
		The Food Service Unit ensures that all meals prepared are safe for human consumption by implementing Pre-requisite programmes (PRPs) of the HACCP system
		Safety procedures are followed.
		The Food Service Unit operates its equipment in accordance to the relevant equipment operating manuals
6.5 Safe and secure environ-ment	The facility buildings adequately protect staff and patients from the elements and from threats to their person, and protects the assets of the facility from theft or damage	Building envelope elements (roof, walls, windows and floor) are in sound condition without defects that pose a danger to further damage to the infrastructure or services as a result of weather
		Building floors, walls, ceiling, windows, doors and sanitary fittings pose no danger to patients or staff
		Building electrical systems are in sound operating condition
		Windows are in sound condition and secured to avoid accidents with children or psychiatric patients
		Building entry points are protected from unauthorised entry or intrusion
		Buildings comply with fire safety regulations
		a fire safety plan is in place to manage risk of fire and evacuation of patients
6.6 Design and condition of buildings	The facility has well-designed and functional treatment areas	Appropriate to the level of care, adequate infrastructure exists as demonstrated in several critical areas - Emergency department - Out-patient waiting area - Pharmacy - Operating (theatre) department:

DOMAIN 7: PUBLIC HEALTH

Definition: Public health covers the active collaboration between facilities (both hospitals and PHC facilities) and with relevant healthcare and other organisations and with local communities to ensure an integrated and effective health care system

Intent: To ensure the design and delivery of programmes to promote, protect and improve health; and which will tackle health inequalities and help people to live healthy and independent lives

Action areas in this domain:

7.1 Health promotion and prevention programmes
7.2 Integration of care and community involvement
7.3 Disaster preparedness and response

Area	Organisational standard	Criteria
Health promotion and prevention programmes	Facilities act to promote, protect and improve the health of the community and reduce health inequities	Facilities ensure that needs assessment and sound public health advice inform their plans, policies and practices
		Facilities actively assess and promote access by the population in their defined catchment area, especially where problems with access have been identified
		Facilities have systematic, appropriate and actively managed disease prevention and health promotion programmes (including wellness programmes for staff) in accordance with national and provincial guidelines; with a focus on: • Non-Communicable Diseases • Mental Health • Mother and Child Health • HIV, AIDS & STIs • TB • Nutrition
		Facilities encourage and support individuals to recognise their own responsibilities in maintaining their health and wellbeing and practising a healthy lifestyle
7.2 Integration of	Facilities work in partnership with Local	Protocols exist to guide integration and partnership with Local Government in critical areas e.g. water and sanitation

care including community involvement	Government / District Authorities and communities in the development, implementation and evaluation of health programmes	Facilities have mechanisms in place for liaison with and support to community organisations
		Treatment and referral protocols used in the facility follow national and provincial treatment and referral guidelines for specific groups or conditions, especially: • maternal health / Obstetrics • child health / Paediatrics • Mental health / Psychiatry • Non-communicable diseases / Medicine or other • Communicable diseases (e.g. TB, HIV & AIDS) / Medicine
7.3 Disaster preparedness and response	Facilities protect the public in the event of significant infectious disease outbreaks or other health emergencies	• There are plans in place to deal with outbreaks in the facility or in its catchment area
		• There are plans in place to deal with disasters or emergencies affecting the facility or communities in its catchment area

BIBLIOGRAPHY

- National Drug Policy. Department of Health, 1996
- Draft National Infection Prevention and Control Policy for TB, MDR TB and XDR TB. Department of Health, 2007
- Recommended Minimum Criteria - To Improve Access to health Care Facilities for Disabled People. Department of Health, 2002
- A Policy on Quality in Health Care for South Africa. Department of Health 2007
- The National Infection Prevention and Control Policy and Strategy. Department of Health 2007
- A Comprehensive Primary Health Care Service Package for South Africa. Department of Health, September 2001
- Improving Quality of Health Services - Actioning of the 12 Point Plan. Department of Health 2006/2007
- Summary and Resolutions of the 2nd Biennial Public Hospital Management Forum. Department of Health 2007
- Progress Report on Hospital Delegations. Department of Health, Undated
- Action Plan on Hospital Improvement. Department of Health 2005
- Hospital Improvement Plan – presentation to CEO Forum. Department of Health, 2006
- Hospital Revitalisation: Project Implementation Manual. Department of Health,2008
- Draft Guidelines for the Continuum of care for HIV and AIDS and Related Diseases. Department of Health,2007
- Draft Standardised Discharge summary. Department of Health, 2006
- Electronic Health Record National Strategy. Department of Health, 2006
- National xx for the Effective and Equitable Development of Tertiary and Regional Hospital Services. Department of Health,2004

- Joint Commission International: Accreditation Standards for Hospitals. Joint Commission, 1998
- Standards for Better Health. Department of Health (UK) 2004
- National Standards, Local Action: Health and Social Care Standards and Planning Framework. Department of Health (UK) 2005/06-2007/08
- Healthcare Standards for Wales. Welsh Assembly Government, 2005
- Standards for Hospitals. Council for Health Services Accreditation of Southern Africa, 2006
- Australian Council on Healthcare Standards. February 2008