ETHIOPIAN HOSPITAL ALLIANCE FOR QUALITY (EHAQ)

EHAQ CYCLE III (2019-2020)

EHAQ AUDIT TOOL

CLINICAL SERVICE DIRECTORATE/FMOH

FORWARD

Welcome to the third cycle of the Ethiopian Hospital Alliance for Quality (EHAQ) Hospital site validation team. Whether you have recently join the team from within the Federal Ministry of Health (CSD)/Partner Organization/Agency or you have worked with us on EHAQ activities for some time, we are excited to have you on-board and to work with you. Your contribution will be an integral part of this EHAQ cycle facility level validation success. In order to help you perform at your full potential and create an enjoyable and objective hospital level validation, we are providing you this hospital Site Validation Handbook to inform you of the tools to aid your work as member of the validation team.

As an EHAQ hospital Site Validation Team Member you have an obligation to take care of this handbook for your reference before, during and after all hospital site validation visits and maintain confidentiality of all information you will access as part of your work. Do not discuss regional or facility level information with persons who are not team members or otherwise privacy or have the right to know such information.

Please take time to thoroughly review this EHAQ Hospital Site Validation Handbook, noting how each relates to areas of your health facility site visit validation work. Pass along any questions or concerns you may have to your team leader. We look forward to your objective professional contribution and are confident you will find your experience with this work dually rewarding.

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Director, Clinical Service Directorate
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ACKNOWLEDGMENT

The Federal Ministry of Health Clinical service directorate appreciates the contribution of EHAQ Audit team which was instrumental in drafting the entire document of the audit tool without which the quality of the document wouldn't have taken the current form in the publication. We congratulates the multi-disciplinary team and would like to acknowledge the critical contribution the following individuals deserves a special recognition for their robust and sound inputs collating all available information and putting their best efforts in preparation of the final Audit tool document.

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INTRODUCTION

Hospitals have always played an indispensable role in the prevention, diagnosis, treatment, and management of diseases in a given community. Despite all the efforts made, in Ethiopia, needs of hospital customers have been growing with notable disease dynamism. Presently, the hospitals infrastructure and quality service for all service types remain in nascent stages in most of the regions of the country. In order to meet or exceed customers' needs, Hospitals are expected to systematically audit their status and improve their limitations through consistent quality management system implementation.

Healthcare audit is used to be practiced globally as well as in our country using various approaches for several years and it is an essential tool for Continuous Quality Improvement (CQI). It is a process used by health care professionals to assess, evaluate, and improve patient care in a systematic way. The audit measures current system and practice against a desired standard which aims to ensure a high quality of care for patients. Quality improvement activity is becoming a day to day practice by various healthcare workers in different Hospitals.

The main purpose of EHAQ audit is to monitor Hospitals as to what degree standards are met, identify reasons why they are not met, and develop and implement desirable changes to practice to meet the standards with objective evidence. .

Hospitals participating in the EHAQ program are expected to be evaluated against the requirements set accordingly once they are ready for the assessment. This audit will be carried out first by the Hospitals internally as self-assessment, and once they implement those requirements, they will be audited externally by trained assessors authorized by the ministry. The audit checklist is designed to address Cleanliness and Timely Care measurable standards as well as the performance of Institutional Transformation initiatives which has been implemented by Ethiopian Hospitals for a couple of years. The key customers/stake holders for this initiative are Patients, Hospital leadership, Quality Management team, Infection Prevention team, staff, and visitors, FMOH, RHB, and Development Partners. The EHAQ audit tool can be used by all those stakeholders for training, mentoring, supportive supervision purposes and the national EHAQ audit team uses to support Hospitals and eventually used to auditing and recognition purpose.

Hence, the EHAQ further provides a learning opportunity for continuous quality improvement of health care service and helps as an ideal mechanism for identifying and managing resources effectively and efficiently.

EHAQ AUDIT TOOL OBJECTIVES

The focus area for the third EHAQ cycle is to achieve a high level of cleanliness of care and timeliness of care. The key objectives of the cycle and this audit tool are:

- To assess the level of health facilities on cleanliness of care and timeliness of care and provide onsite support for identified areas of improvement.
- To select regionally and nationally best performing health facilities based on selected cleanliness and timeliness standards and recognize their achievement.
- To provide a standard of service that brings a positive image for the hospital and realize socially acceptable environment for patients, visitors and staff, 365 (7) days of the year, 24 hours per day.

EHAQ AUDIT TOOL SCOPE

This audit is designed to address system, practice, and performance towards quality focusing Cleanliness and Timely Care and Institutional Transformation initiatives.

This audit tool assesses 6 different areas with a number of standards under each theme.

S.No	Focus area initiative	Score	100% (Percentage)
1.	Cleanliness of care and timeliness of care/CATCH/	120	40%
2.	EHSTG	60	20%
3.	Data quality and DHIS 2	30	10%
4.	SaLTs	45	15%
5.	Pain free Hospital Initiative (PFHI)	15	5%
6.	Cluster activity (EHAQ networking and engagement)	30	10%
Total Score		**300**	**100%**

AUDIT SCORING

To reach a rating, assesses each requirement and take account of objective evidence.

For each requirement, please circle or make a tick mark as relevant Yes (Y), or No (N) or Not Applicable (NA), all verification criteria of the item must be satisfactorily present to indicate "Yes". Provide explanation or further comments for each "No" or "NA" response. For each standard, use the verification criteria listed to assess the presence or absence of evidence. For further information, follow "Auditor's Quick Guide". The total audit score will be calculated as follows:

$$\text{Total Audit Score Percentage} = \frac{\text{total score X 100}}{300}$$

AUDIT SECTIONS

This audit tool has four different sections as described below:

SECTION I: Hospital profile

SECTION II: Cleanliness and timely care audit

SECTION III: Institutional transformation audit

SECTION IV: Audit finding summary

SECTION IV: Auditors Quick Guide

SECTION I: HOSPITAL PROFILE

Hospital Information	
Date of Audit	
Hospital's name	
Hospital Address (Region, Zone/Sub city, District/Woreda)	
Contact Information	Hospital CEO/CED: ______________________ Hospital Medical Director/CCD: ______________________ Hospital Quality Unit Head: _________________________ Tel No. Fax: Email:
Level of the hospital	Tertiary ☐ General ☐ Primary ☐
Staff Profile	**Number**
Specialist	
General Practitioner	
Nurse	
Health Officer	
Medical Laboratory Technologist/Technician	
X-ray technician	
Pharmacy	
Other	
Name of Auditors	**Signature**
1	
2	
3	
4	
5	

SECTION II: CLEANLINESS AND TIMELY CARE (CATCH) AUDIT (40%)

Section II (a). Timeliness of care Audit tool

Description: Timely care is a provision of care based on patient needs and an urgency of the medical situations including prompt planning of discharge.

Standard and criteria **1. Timely care**	Yes/ No	Score	Data Source	Remark
S 1.1 Better Appointment system is in place		**9**		
C1. All admission go through the liaison office		1	Check randomly 10 cards from different wards (Major wards) and verify recorded at liaison register.	
C2. All inpatient appointments go through the liaison office		1	Check randomly 10 MRN of IPD appointed patients from laison register and check against inpatient register	
C3. The hospital has updated admission discharge protocol clearly stating that all admission and discharge goes through liaison.		2	Check the availability of updated hospital admission discharge protocol	
C4. OPD appointed clients directly go to specific service areas without being triaged		2	Interview 6 clients from different chronic OPD. Check MR retrieval of appointed clients prior to clients' arrival.	
C5. Divide the appointment day into blocks of time		2	Observe OPD appointment log book and verify the day divide into blocks of time (morning and afternoon, specific time of the day) Interview 5 patients	
C6. Use of phone calls or reminder text to already appointed patient to remind specific appointment day and time		1	Interview randomly 5 appointed patients who get service	
S 1.2 Early initiation of hospital		**6**		

service and service time recorded				
C1. Ensure early initiation of triage and medical record (at least one hour a head of service time)		3	Observation of service started time Check the first patient triaged time and MR registration time	
C2. All OPD started at 2:30 local time		3	Observation of all OPDs that patients are assigned by triage officer and started 2:30	
S1.3 Emergency Service is delivered without delay		**8**		
C1. All emergency patients triaged within five minutes of arrival		2	Check patient triage within five minutes on Emergency registration book Check the facilities did survey (see the survey report) observation	
C2. Check early disposition of patients to respective destinations is implemented		2	Observe emergency log book for patient stay greater than 24 hour. Interview 5 Clients Check senior round schedule	
C3. Emergency department lay out and preparedness		2	IS ambulance parking near Emergency area Check the triage area situated at the entrance of the ED and has sign Check the availability of emergency drugs in crash cart at ER	
C4. Senior physicians make round at ED 2x daily		2	Check round schedule posted Chart review(3 charts)	

			for senior physician documentation	
S 1.4 Discharge plan is well documented and communicated for every admitted patients		**7**		
C1.Availability of SOP for discharge planning		3	Check the presence of SOP for discharge planning at selected 3 wards	
C2. Discharge plan for every admitted patient is well documented and communicated based on the SOP		2	Chart review (10 patients) from discharged patients last 3 months Interview 5 patients know expected date of discharge at the time of admission	
C3. The hospital implements a minimum of daily multidisciplinary team patient rounds and visit services.		2	Check round lead by seniors in each department and conducted daily including calendar days. Check teaching and MDT regular ward rounds scheduled separately.	
S1.5 Better queue management systems		**6**		
C1. The hospital introduced smart/manual queue management system is in place		6	Observation Medical record unit, Triage, OPD, and Pharmacy and Laboratory Interview assigned staff working on queue management system	
S1.6 Optimum capacity for liaison service		**12**		
C1.The hospital provides liaison services 24 hours in a day and 7 days a		3	Observe the designated office with the necessary equipment (computer, table, phone, Shelf,	

week throughout the year.			Registration book Full time staff at least 2 at any time	
C2. all referral out service are properly communicated to the receiving facility		3	See referral registry last one month Call to 5 patients or attendants referred out in the last one months	
C3. The hospital has bed monitoring system		3	Observe Liaison office log book Check beds are counted 3 times(8 hourly) per day Cross check bed occupancy	
C4. Documentation of elective admission waiting list with clear appointment date		3	Elective admission appointment log book	
S1.7 Increase OR efficiency		**6**		
C1. Elective surgeries started at the beginning of the working hour		2	OR schedule Observe the time of surgery started for elective cases from from patient chart/ anesthesia sheet.	
C2. All patients planned for elective surgical admission are pre communicated one week before surgery		2	Interview 3 patient of elective surgery conducted. Check the appointment log book include all contact of the patient	

			recorded.	
C3. Elective surgery are scheduled in all working days		2	Check OR schedule for elective surgery in the week for working days	
S 1.8 Avoid/Minimize cancellation		**6**		
C1. Pre-operative evaluation and investigation were completed before admission of patient.		3	Check pre-operative format is attached and recorded before admission (5patients) Check all investigations are done at list a day before elective surgery admission Check consent-form is signed before surgery day Check all pre-operative preparation is done (Abdominal preparation, Prophylactic drugs and counseling) before surgery done Interview 5 patients	
C2. Blood is available in their stock		1	Visit mini blood bank and observe that all types of blood is stored in the mini blood bank Check surgery cancelled or referred due to lack of blood for the last one months from Laison registry/OR log book	
C3. Supplies and equipment checklist filled for all procedure before a day of surgery		2	Observe the check list and verify that it is filled for the 5 random procedures.	

Sub-total score for Timeliness of care	**<u>60</u>**

Section II (b). Cleanliness of care Audit tool

Description: Cleanliness in the context of CATCH-IT refers to criteria set in CASH initiative for clean and safe health care service.

Standard and criteria	Yes/No	Score	Means of verification	Remark
1. Cleanliness of care				
S2.1 Cleanliness norms and practice are in place		**40**		
S2.1.1 CASH performance Audit		**5**		
C1. Quarterly CASH Audit performed		2	Review last two Quarters CASH Audit reports	
C2. Written feedback is given for specific departments		1.5	Review written feedback given for at least three clinical departments randomly for the last two Quarters	
C3. Action plans are developed based on audit findings and implementations are monitored by CASH/IPC committee and SMT		1.5	Check action plans, implementation progress report/meeting minutes for the above selected three departments for the last two Quarters	
S2.1.2 Monthly cleaning campaign is performed		**3**		

C1. The hospital has assigned a monthly cleaning day that is known by all staff.		1	Check specific day assigned for cleaning day via minutes Interview 5 staff randomly from different units	
C2. The hospital has conducted monthly cleaning campaigns.		2	Check campaign report and pictures for the last 3 months consecutively Interview 5 staff randomly from different units	
S2.1.3.Hospital compound is clean and tidy		**4**		
C1. Hospital internal grounds are visibly clean and tidy.		2	Observe all the hospital compounds are free from abandoned medical equipment, non-functional clinical waste containers and damped old office furniture/old cars etc	
C2. Presence of clean designated green areas/parks with seating facilities.		1	Observation	
C3. Wastebaskets are placed for non-medical waste and appropriately used.		1	Observe Wastebaskets are appropriately placed and labeled with clear instructions (OPDs, walk ways, waiting areas)	

S2.1.4.Adequate Cleaning equipment and supplies are availed and used		**5**		
C1. Equipment and supplies, needed for cleaning, are available for the last three months(Refer IPC guideline).		2	Check the mini-store and review model 19/22/20 of the last three months.	
C2. All cleaners/housekeeping staff receive capacity building/orientation.		1	Interview 5 cleaners from different clinical areas. Check the minutes/orientation attendance sheet	
C3. All cleaners/housekeeping staff uses cleaning equipment and supplies as per IPC guideline.		1	Observe and Interview 3 cleaners from different clinical areas	
C4. All cleaners/housekeeping staff use personal protective equipment		1	Observation of cleaners on their service areas at least (Labor ward,	

while they are on duty.			Major OR and ICU)	
S2.1.5 All wards and corridor are visibly clean.		**5**		
C1.Floors, walls and ceilings of wards and corridors are regularly cleaned based on their schedule		2	Check the availability of schedule in the specific area (Randomly 3 different wards) and free from medical and non-medical wastes.	
C2.Ward masters are assigned to oversee cleanness of their respective service areas/ward		1.5	Check presence of official letter with role and responsibility for ward masters Observe all ward patients are in Hospital Pyjama Observe all inpatient beds are cleaned and dressed.	
C3.Presence of quarterly recognition scheme for clean wards.		1.5	Check recognition schemes and evaluation report performed on quarterly basis.	

S2.1.6 All OPD and IPD toilets are visibly clean and have functional hand washing facility		**4**		
C1. All toilets are visibly clean		2	Round and observe 3 different department wards and OPD toilets with no blood and body substances, scum, lime scale, stains, smears, as well as, odorless/free of unpleasant smell.	
C2. All toilets have a functional hand washing facility and soap is available at all times.		2	Round and observe 3 different department wards and OPD toilets	
S2.1.7 Kitchen room visibly clean and staff are dressed appropriately		**6**		
C1. The kitchen and food making appliance are clean		1	Check the kitchen floor, cooking surface and washing area are clean	
C2. Food transportation and covering material are in place		1	Check the availability of clean food transportation and covering material	
C3. Staff wear clean cooking dresses, cover their hairs		1	Observe kitchen staff	
C4. Functional **shower is available in the kitchen**		1	Check the functionality of shower service	
C5. Food raw materials are		1	Observe food raw	

appropriately sorted, labeled and shelved			materials storage area	
C6.. Kitchen has an exhaust outlet and is well ventilated		1	Observe kitchen has chimney outlet windows and ventilation	
S2.1.8 The hospital has a functional laundry services		**8**		
C1 Hospital laundries have a functional machine (washing, drying and ironing) with back up.		2	Check presence of functional machines with backups	
C2. The laundry have separate areas for clean and soiled linen storage		2	Observe separate entry and exit routes	
C3. The laundry have separate carts for clean and soiled linen transportation		1	Observe	
C4. Equipment and supplies needed for laundry services are available for the last three months (Refer IPC guideline).		1	Check the mini-store and review model 19/22/20 of the last three months.	
C5. Presence of preventive and corrective maintenance by from Biomedical engineering team		1	Check records for Preventive maintenance according to manufacturer recommendation Check work orders and response at laundry and biomedical unit	

C6. Laundry staffs dressed personal protective equipment.		1	Check working laundry staff dressed personal protective equipment	
S2.2 Optimum instrument processing		**6**		
C1.Functional and consistent operation of autoclave and Sterilization equipment		2	Observe functionality of autoclave at sterilization room.	
C2. Sterilized items are kept in a clean, separate, labeled and enclosed storage area		2	Observations	
C3. Sterilized and wrapped packages are dated and labeled with autoclave indicator tape		1	Check sterilized item for internal and external indicator tape	
C4. All Health workers are aware on 0.5% chlorine solution preparation		1	Randomly interview 5 different health professionals on how to prepare chlorine solution	
S2.3 Hand hygiene practice (HH)		**5**		
C1 Five moments of hand hygiene practice is in place		2	Observe posted notice and Interview randomly selected five clinical staff	
C2. Functionality of hand washing sinks equipped with liquid soap/soap and water availability with backup		2	Check 3 inpatient wards,1Emergency OPD and 1Laboratory Interview randomly selected five clinical staff	

C3. Alcohol based hand sanitizer availability(Inpatient, Emergency and Laboratory)		1	Check 3 inpatient wards 1Emergency OPD and 1Laboratory	
S2.4 Improve health care waste management practice		**9**		
C1. The hospital should have functional color coded and covered waste bins at each service area		2	Observe randomly selected three clinical departments	
C2. Areas for storage of waste awaiting removal from the hospital should be fenced and protected		2	Observation	
C3. Clean and functional placental pit is available.		1	Observe and check placental pit is odorless and distasteful Interview cleaners	
C4. Functional incinerator is available.		1	Observe and check functionality of the incinerator with recommended design	
C5. Domestic waste pit for burning of non-infectious waste and burial pit for the burial of non-combustive waste are available		1	Observe and check the pits are free from odor /offensive smell	
C6. Hospital has proper liquid waste management system.		1	Observe and check sewerage line	

			connected to a municipal or own septic tank. Interview IP head	
C7. Liquid wastes generated from the hospital is treated		1	Observe and interview IP head	
Sub-total score for Cleanliness of care				**60**

SECTION III: INSTITUTIONAL TRANSFORMATION INITIATIVES

Hospitals are expected to transform hospital service quality with the listed prioritized initiatives that have been under implementation at all level of hospitals in the country:

1. Ethiopian Hospital Service Transformational Guidelines implementation
2. Data quality and DHIS 2 implementation
3. SaLTS implementation
4. Pain free Hospital Initiative
5. Cluster activity (EHAQ Networking)

Section III (a): Selected EHSTG Audit tool (20%)

Description: The Ethiopian Hospital Service Transformation Guidelines (EHSTG) tool for 2019/2020 EHAQ onsite validation has been developed to describe the criteria for the attainment of standard requirements specified in the EHSTG document under 8 of the 20 chapters of both volumes. Chapter areas like IPC and facility management covered in the CATCH audit tool and the HR and Finance and Asset Management chapters are not included in this tool.

<table>
<tr><td colspan="5">CHAPTER 1: HOSPITAL LEADERSHIP, MANAGEMENT AND GOVERNANCE (5 point)
Key note: -Hospital leadership, management and governance skills are essential to ensure effective, efficient and quality hospital services and good governance for health is a mission-driven and people-centred decision-making process. so hospital leaders require a unique set of skills to both manage their organization/department and to liaise with external agencies and the local community that lead them to identifying and solving any challenges to the better success of their hospital.</td></tr>
<tr><td>S.N</td><td>OPERATIONAL STANDARDS</td><td>VERIFICATION CRITERIA</td><td>Met</td><td>Unmet</td></tr>
<tr><td>1.</td><td>The hospital has a functional governing board (GB) meets regularly to oversee the overall operations and service delivery of the hospital.(0.5 point)</td><td>• The board is established in accordance with a legislation
• GB develop its own strategic plan discussed with possible stake holders and staffs
• Governing Board(GB) develop its annual plan and Term of reference (TOR) all approved by all members
• Standing committees of GB established and functional
✓ Resource mobilization/ finance committee,</td><td></td><td></td></tr>
</table>

		✓ Executive/Community forum committee • GB meets in accordance with a relevant legislation at least every quarter: ✓ *Approve plan & TOR annually* ✓ ***Evaluate*** over all hospital ***performance*** including ***status*** of HSTQ/QI projects graduation as major indicators ✓ Oversee ***Feedbacks*** to the hospital from relevant bodies (***if there is***) • Check minutes that agendas are strategic/relevant, • Check agenda set 3 – 7 days prior to meeting, ***approves*** previous meeting • Check implementations and follow up as per the ***plan*** &***TOR*** • Check mechanisms of hospital site visit of GB with senior management team(SMT) • Check mechanisms of ***tracking*** of SMT regular activities by GB		
2	The hospital has a ***functional*** SMT that meets regularly to manage and execute the overall hospital operations.**(1 point)**	• Obtain organogram and check its membership include at least major department heads o Check SMT ***membership*** approved by GB • SMT develop hospital ***strategic*** plan and approved by GB &staffs • Check A***nnual*** plan discussed with community and approved by GB • SMT develop ***its own*** annual plan and TOR both are discussed and signed by all members • SMT Meets at least ***every two weeks*** on ***performance evaluation*** • including ***HSTQ/QI projects***		

		• Sub committees of SMT are established (quality committee, DTC,…) and implement their functions as per the **plan** and **TOR** • Check mechanisms of SMT to identify gaps of case teams, solve and provide feedback • The SMT submits regular report to GB and relevant bodies ✓ Check GB & SMT set a schedule to evaluate hospital performance at all level in accordance with HMIS/KPIs timeframe ✓ Check ***evaluation meetings& time of reports whether*** with • ***HMIS and KPIs time frame*** both for GB & SMT		
3	Hospital has a ***well-functioning*** Development army(**0.5 point)**	The hospital development army established as per the guideline and check at least: • Regular 1 to 5 & Developmental Group networking • Transformation forums conducted regularly • ***Clinical forums:*** ✓ Daily Clinical forums for Primary hospitals (***all disciplines)*** ✓ Daily clinical forums on department basis for General and above hospitals(***with composition of all disciplines***) ✓ Clinical forums with at least 1 times per week as a group (***all disciplines***) for general and above hospitals • Community forum conducted at least ***every quarter*** lead by GB chairperson (***Vice chair if not available***):		

		• Check ***saved audio- Visual*** documents with the ***date*** ➢ Check minutes for community voices brought for discussion ➢ Check for implementations of gaps and Feedbacks ☐ Regular hospital staff forums conducted every quarter (*lead by at least a GB member other than staff representative*) ➢ Check minutes for staff voices brought for discussion ➢ Check for implementations of gaps and Feedbacks ☐ Citizen charter is prepared and communicated well to the community & staffs on annual basis(see minutes, Quality Unit activities) • Check the charter whether updated at least every ***two years***		
4	The hospital governing board has a plan to mobilize resources from diverse sources and makes sure resources are utilized effectively and efficiently.**(0.5 point)**	• Check GB specific ***resource mobilization plan***, its implementation and evaluation • Check stake holders involvement (*community, NGOs, Government sectors,….)* in raising funds • Check finance/ resource mobilization committee activity whether changes in the hospital in line with the plan		

5	There is a system and practice of measuring performance and results, appraisals and recognition system for departments and individual best performers in the hospital. (**1 point)**	• View the BSC documents and performance expectations plans are submitted by each departments and are approved by SMT *(check minute for approval, BSC documents of individuals in 3 randomly selected service areas)* • The performance of each departments and graduated QI projects are reviewed and feedback is provided at least every 2 weeks with actions for the gaps(***check***minutes***and***reportsforSMTin***3departments***) • Performance appraisals done with at least posts of best performer departments and individuals (possibly by names & photo) at least on ***quarterly basis*** after ***result approval*** by SMT and GB • A system of recognition is established for each departments and individuals best performer at least ***annually***. O Check selection criteria and possible recognition mechanisms discussed with ***staffs*** and approved by SMT & GB		
6	The hospital SMT and GB has ethics violation reporting, complaint handling and management/reporting system. **(0.5 point)**	• Check SMT orient staffs on code of conduct and CRC at least biannually • Check evaluation & reports of ***Ethical violation*** to relevant bodies (e.g FMHACA) with follow up for actions (*if there is)* • Hospital has mechanisms of complaint handling and management systems regarding Ethical &/or code of conduct violations in services area discussed by SMT every month, quarterly by GB (***if necessary***) • Check awareness of ***staffs and clients*** whether there is complaint handling & management by GB &SMT		

7	The hospital has a ongoing ***capacity building*** program both for GB members and SMT(**0.5 point**)	• There is a formal training & ongoing orientation program for the GB and SMT
		  • Check minutes, orientation documents addressing necessary topics ***(see appendix B in the Guideline)***
		  • Check new members of GB and SMT receive a thorough
		• Orientation before attending their first meeting.
		• Assess knowledge of GB & SMT members (***at least 2 of each***)on their over a1l functions		

8	The GB, SMT & CEO is evaluated every six months consistent with FMOH or Regional Legislation to ensure meeting operational and strategic plans of thehospital(**0.5 point**)	Obtain a minute of a meeting held on self-assessment of GB and SMT conducted every six month (***team and individual basis***) • Check evaluation ***tool customization*** (*in line with hospital mission*) • Check GB members evaluation *held every 6month* • Check whether the CEO is evaluated by the board every 6moth, • Check SMT self-evaluation every 6month • Check the performance appraisal is submitted to relevant bodies		
		TOTAL		

CHA PTER 3: EMERGENCY MEDICAL SERVICES (5 point) ***KEY Points:- Emergency Medical Services (EMS) overall are a network of services and resources coordinated to provide aid and medical assistance from primary response to definitive care that can be given in a pre-hospital or hospital setting addressing all the domains of Acute Care to save lives*.**				
S.N	**OPERATIONAL STANDARD**	**VERIFICATION CRITERIA**	**Met**	**Unmet**
1.	The hospital has an emergency department led by an emergency director / case manager with customized JD for the department and individuals.**(0.5Point)**	View the organizational structure, annual and QI plan View customized JD (*department &individuals*) Focal person assigned for oxygen supply and management for emergency service areas work with other stake holders in the hospital (*Finance, General service*) Regular service area performance M& E including indicators in the chapter with identified gaps, QI projects, Emergency death audit gaps and actions taken (*mainly of 3rd. delay)* Check adherence of front line staffs to all activity including nursing/midwifery service management for all those admitted more than 24hrs Check nurses assess and manage the 4 P's for critical patients (***Pain, Position, Posy and Possess***) Runners/porters trained at least on transport of samples &requests, patients, confidentiality of Pt. information…) Check assignment of security guard, runners, patient assistant,..	`	

2	The hospital has an Emergency Triage, staffed with necessary infrastructure, appropriately trained personnel and equipped with necessary equipment, drugs and supplies needed to provide quality emergency medical services.**(1 point)**	• Check dedicated area/room for emergency triage • Asses the availability of drugs and equipment (see annex) • Staffs are trained to conduct emergency patient triage and emergency care (*check certificate*). • Check regular emergency supply stock monitoring and handover during each shift • Check for availability of pulse oxiymetry, oxygen concentrators, gas analyzer (optional for primary and general hospitals), • Check document all oxygen cylinders cleaned at least every year • Oxygen plant at least in major wards, ICU, OR and emergency (***for specialized hospitals***)		
3	The hospital has easily accessible Emergency department with an ambulance parking area.**(0.5point)**	• Hospital has ***separate gate*** (***optional for primary hospitals)*** with trained receptionist(at least BLS, IPPS,…. with reflective jacket) • ER unit is labeled properly and visible from the distance including night time (red background with white notes, illuminated, multilingual) • Check the department near to the gate, easily accessed/ground floor • Check mechanism of communication and ambulance utilization management - among departments and facilities • Check isolate ambulance parking area (*visible at night*)		

4	The hospital shall establish efficient flow of Patients in the emergency department**.(1point)**	• Confirm that the emergency unity is organized based on the following areas; (***optional for primary hospitals, but it is mandatory to avail all services***) • Patient assistant area at Emergency gate with supplies • Triage area • Waiting area for non-critical emergency patients • Examination area • Isolation room • Resuscitation area • Procedure area • The observation and treatment area(beds for24hrs) • Emergency OR (***for primary hospital easy access to main OR***)		
5	The Emergency Department/Unit shall use a triage system of screening and classifying patients to determine their priority needs and to ration patient care efficiently.**(0.5pont)**	• Observe separate pediatric and adult triage area (*optional for primary hospital)* • Observe at least ***color coded rooms*** to prioritize patient care for adult and ETAT based triage for pediatric • Regular patient acuity level assessment with Triage formats attached • Confirm 6 MRNs (3 adult and 3 pediatric) from HMIS register in the last quarter, retrieve the charts and verify all of the following: • Triaged within 5 minutes of arrival • The patient is appropriately classified as per the severity with appropriate and timely management		

6	The hospital provides emergency medical service 24 Hours a day with a 24-hours' access to diagnostic laboratory, radiology and pharmacy services.**(0.5point)**	• 24 hr emergency Pharmacy service (*check 3 randomly selected emergency prescriptions/sale tickets in the last quarter and drugs availed from ED on date of order*) • 24 hr emergency Laboratory service – (*check 3 randomly selected emergency Lab. requests from ED register in the last quarter and tests are done in ED Laboratory*) • 24 radiology and ultrasound service (*for primary hospitals: 24hrs access to main X-ray and U/S with a prioritization mechanism for emergency patients)* • Check 3 randomly selected emergency X-ray/Ultrasound requests in the last quarter done on the date of order) • Check mobile x-ray for general and above hospitals		

7	There is emergency response plan for both internal and external disasters with a system to alarm or communicate personnel and other stakeholders.**(0.5point)**	• Check the assignment of emergency response coordinator (incidence officer) and ask his duty in case of disaster
		• View comprehensive emergency response ***plan*** of the hospital and verify if the plan includes a mechanism to:
		  • Mobilize for more human resource from within or outside the hospital
		  • Avail more drugs and supplies and even share other resources with other departments within the hospital itself
		• Check orientation given to the staffs and their adherence
		• including call from home to manage disasters during duty hour		

8	Emergency department or Unit has policies, protocols, flowcharts, consultation and treatment guidelines for running ED/EU.**(0.5point)**	• View presence of policies, protocols, flowcharts • Check Consultation communication guides among professionals and departments and adherence among staffs • Check Treatment guidelines (ETAT, Adult and Pediatrics…) • Check availability of oxygen administration and management protocols and SOP based on the client needs, monitoring…		
		Total		

CHA PTER 6. MEDICAL RECORDS MANAGEMENT (5 point)

Description:-*Medical Record Management (MRM) is critical to improve the provision of continuum of quality health care services, ensure safe medical practice, improve thepatient'sexperienceandsatisfactionwiththeirmedicalencounter.Ithelpsalsotomakeclinicalandpublichealth evidencebasedpractices,makinginformeddecisionsandusedasreliablesourceofinformationformedico-legalissuesandmedical/public health researchers.*

S. N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	Unique medical record number is assigned to a patient during his/her first visit of care.**(0.5point)**	• Select randomly 10 MPI cards of the previous years and confirm: o They registered in the computer/smart care/, each MR number unique to a client, properly kept and easy to retrieve		
2.	The hospital shall have a single unified medical registration unit for all patients' registration**.(0.5point)**	□ Confirm that only one registration system exists for ALL patients □ If there is separated registration on service categories with in the unit, ensure the system is interconnected for numbering of MRs □ Take 5 tracer cards and Check availability of their correspondent MRs in the hospital □ Check supplies and electric system is available 24 hr. in the MR room		
3.	The hospital utilizes paper and computer-based systems to register and retrieve medical records**.(0.5point)**	• Observe the utilization of both manual and computer based MPI for 24hour • View MR tracking system whether computer and/or patient service card used o Take 5 MR from registry and check time of retrieval whether with in the standard		

4.	The hospital avails and utilizes a standard set of formats that comprise a complete medical record for continuum of patient's care.**(1 point)**	• Hospital set standard/policy for patient formats filing in the folder • Randomly sample 10 inpatient medical records admitted in the past year, and confirm that each, as a minimum: ✓ All forms in the client folder are of same (A4)size ✓ Check formats with in the folders are well attached and intact ✓ Check formats in the folders attached in orderly manner according to hospital policy		
5	The hospital shall implement and comply with national guidelines to manage access to patient's medical records.**(0.5 point)**	• Interview medical records staff and confirm national guidelines on handling and confidentiality of medical records are known by all staff. o Confirm if there is separate locked MR store available for medico-legal cases with proper handover. • Check Staff orientation on confidentiality of MRs, MR access policy,…		
6	The hospital performs medical record auditing, data quality checks, archiving/culling procedures and takes corrective actions on a regular basis.**(0.5point)**	• Check MR audits at least biannually to check/focusing on: ✓ Patient folders missing from the shelf ✓ Summary sheet of each folder for all visit are dated and filled properly ✓ Complete ness of formats (each formats with authentications) ✓ Availability of tracer card in each folder, ✓ Check actual MRs archived or destructed etc ✓ View audit reports &documented evidence that shows action taken based on audit findings, ✓ See M & E of indicators in the MR chapter ✓ View proper shelving of medical records • View store prepared for archiving of MRs (inactive for more than 2years)		
7	The hospital ensures patient's medical records return from different service units to medical records unit at the end of each service day in accordance with medical record tracing system.**(1 point)**	• Check tracer card prepared to all client folders • Confirm there is daily balance done for MRs distributed at OPDs with the return at end of each service day • Check mechanisms to return MRs of admitted clients with in 24 hrs. of discharge • Check handover system of MRs b/n MR department and service areas • Check communication mechanism to completeness of MRs among Service areas >liaison office >MR department		

8	The hospital shall automate health information system through implementation of integrated electronic medical record system**.(0.5 point)**	• View and confirm implementation of integrated electronic medical record(eMR) systems in the hospital ✓ Check service areas for functionality • Check back up systems (UPS, 24 hr. Electric supplies…)		
		Total		

CHA PTER 7. NURSING AND MIDWIFERY CARE SER VICES MANAGEMENT (7 point)

Description:-*Nurses and midwives are professionals who are committed to the development and implementation of standardized practices throughhongoingacquisition,applicationandevaluationofknowledgeandskills.Nursingandmidwiferyservicesareexpectedtoprovidepeople centered continuum of care with competent, safe and ethical care in fully accountable and responsible manner for their entire practice through which they needed most to improve the health outcomes of individuals, families and communities in general.*

S.N	STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital has established nursing midwifery service management structures and job descriptions that detail the roles and responsibilities of each nursing and midwifery professional, including reporting relationships.**(0.5 point)**	• Check for nursing midwifery representation in the SMT; • The hospital established management structures that detail the roles and responsibilities of nursing midwifery professionals with customizations of JD as a group/ individual including reporting and communication relationships • Check operational plan approved by SMT with ***its implementation*** regarding: ✓ Nursing midwifery practice to ensure quality ✓ Capacity building of students toward holistic nursing midwifery services ✓ Follow up on competency on patient care with stakeholders ✓ Nursing midwifery day to day learning sessions/peer reviewing using ▪ In service training ▪ Grand round ▪ Journals reading and update each other ▪ Online searches related to practices and update each other ▪ Discussions with colleague		

2.	The hospital has a nursing and midwifery workforce plan that addresses nurse /midwife staffing requirements and sets minimum nurse /midwife to patient ratios in each service area.**(0.5 point)**	• Obtain copy of nursing midwifery staffing plan and confirm this establishes nurse/midwifery to patient ratios for each service area • Confirm the plan identifies mechanisms to reassign nursing/midwifery staff or call in extra staff to ensure that minimum nurse/midwife to patient ratios are maintained • Check there is Orientation and f/up mechanisms during transfer of nurses/midwives in clinical settings		
3.	The hospital has written policies describing the responsibilities of nurses and midwives for the nursing/midwifery process including the admission assessment, planning, implementation and evaluation of nursing/midwifery care**.(1 point)**	• Identify written policies that describe the nursing midwifery process. • Verify that the following are addressed: ✓ Nursing midwifery admission assessment ✓ Nursing/midwife care planning, implementation and evaluation for all admitted patients		
4.	All admitted Pts and mothers and emergency patients/clients have a nursing/midwifery care plan that describes holistic nursing/midwifery interventions to address their needs**.(1 point)**	• Select a random sample of 5 emergency and delivery ward cards(***stay >= 24 hr)*** and Confirm that each contains a complete nursing care plan, medication records including oxygen, order sheets including oxygen,…. **<u>All</u>** updated regularly • Select randomly selected 5 IPD cards and Confirm that each contains a Complete nursing care plan, medication records including oxygen, order sheets including oxygen,…. Updated regularly		
5	All hospital nurses/midwives comply with the professional code of conduct and ethics which governs their professional practice. **(0.5 point)**	• Does the hospital provide a written professional code of conduct and ethics to all nurses and midwives? • Does the hospital provide complete uniforms for nurses/midwives and do they comply with National/Regional dress code all the time • Does the hospital have a system to evaluate and report illegal, incompetent or impaired practices to relevant bodies? • Check 5 randomly selected nurses/midwifes for awareness of their code of conduct • Check 5 randomly selected clients for awareness of uniform coding of hospital nurses/midwifes • Do nurses and midwives implement CRC(using HSTQ)		

		• Check by interview clients from different wards for CRC practice		
6	The hospital has established guidelines for verbal and written communication about patient/client care that involves nurses/midwives and their patients/clients, families, other case team professionals of the disciples, including verbal orders and timely documentation of accomplished activities.**(1 point)**	• Does the hospital provide written guidelines regarding verbal and written communication and documentation? • Do nurses and midwives seek constructive feedback regarding their own practice from hospital management/QU/? • Does the hospital/nursing midwifery management have a systematic of peer review? (***Senior nurses supervise, mentor and coach regularly to support the junior nurses***)?		
7	The hospital has standardized procedures for the safe and proper administration of medications by nurses or designated clinical staff.**(1point)**	• Does the hospital prepare ***central/room cabinet*** to ensure medications are not placed at patient side? • Identify written procedures for process of medication administration. • Verify that procedure addresses safety, proper administration, and administration authority. • Check Oxygen prescribed, administered and monitored as vital sign (***for the needy only)*** • Review 10 Medication Administration Records (03MRs *with oxygen administration*) from different wards and confirm that each is completed correctly with the signature of the transcriber and of the individual who administered each medicine dose.		
8	The hospital has established nursing/midwifery care practice audit program, including the documentation of completed audits and resulting practice improvements.**(0.5 point)**	• Does the Hospital have a Nursing/midwifery Audit Committee? • Does the Nursing/midwifery Audit Committee meet regularly and conduct a nursing/midwifery service audit?(*check with TOR, Plan, HSTQ*) • Do Nurses/midwives participate in *death review* to improve the quality of healthcare? • Do Nurses/midwives collaborate with the inter-professional team (CRC,QU,…) to implement quality improvement plans • Do Nurses/midwives incorporate evidence based best practices (collect data, analyze trends,….) including chapter indicators to improve health outcomes?		

		• Look for a nursing/midwifery audit report and follow up • Look for action plans to implement gaps identified by audits		
9	The hospital implements nursing/midwifery eight hours' shift and regular rounds. **(0.5 point)**	• Is the hospital implementing 8 hours shift of nursing/midwifery service? • Do the nursing/ midwife staffs conduct all types of rounds (shift round, individual/1hr, group nursing and grand round) ? ✓ Check adherence to the protocol/guideline • Check nurses & midwifes do hourly round for critical ill patients addressing the 4 P's (Pain, Position, Potty and Possess)		
10	The hospital has a centralized nursing/midwifery station set-up in each ward with adequate space, equipment and consumables.**(0.5 point)**	• Does each unit have the necessary equipment and supplies to accomplish nursing and midwifery care practice? • Does the unit have equipment for specific min or procedures? • The station should have necessary guide lines, reference materials… • Station should have facilities for refreshment to on – duty staffs		
		Total		

CHA PTER 8. MATERNAL, NEONATAL AND CHILD HEALTH SERVICES MANAGEMENT(8 point)

KEY Points:- ***Nurses and midwives are professionals who are committed to the development, implementation/ practice of standards to ensure highest quality of care during antenatal, delivery and postnatal periods targeting essential maternal and newborn care and management of complications that could achieve the highest impact on maternal, fetal and newborn survival and well-being.***

S. N	OPERATIONAL TIONASTANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital ANC unit provides individualized, client centered and evidence based care to clients on all working days and high risk mothers should be seen in the referral clinic.(**0.25 point)**	• ANC unit is established under outpatient department and a unit coordinator is assigned with customized JD • ANC service is provided during all working hours of working days • There is a mechanism to screen high risk mothers and provide care by the senior health care providers in all working days of the week (IESO or Obstetrician in nonteaching hospitals, final year resident or obstetrician in teaching hospitals) • Focused ANC service is implemented (according to guide line, regular orientation for midwives at least biannually) • Check both visual and auditory privacy is maintained • Check all referred mothers seen by higher level of profession(from referral registration) • Check all MNCH services monitored and evaluated including chapter indicators related to plan and action taken to identified gaps • There is a mechanism to facilitate and prioritize pregnant women for hospital services like laboratory services o Check Lab. TAT for pregnant mothers o Lab. and MCH staffs awareness on prioritization,		

2.	The hospital should ensure provision of Comprehensive Emergency Maternal and Newborn Care (CEmONC) services **(1 point)**	• Interview the maternity head if all CEmONC functions are available all the time • All surgical teams including obstetricians are on duty and stay in the hospital compound during duty hours • Safe surgical checklist and standardized operation note and register documentation is used for ***all*** major surgical interventions • Verify service provision through Chart audit from the previous quarter performance – select 5 MRN from HMIS operation register and – verify if: • Safe surgery checklist is properly filled, • Operation note includes at least date of surgery, time of skin incision, • Identification of client including her MRN • List of names of all surgical team,– surgeon, assistant anesthetist/anesthesiologist, scrub, runner, • Preoperative diagnosis, • Type of procedure, • Postoperative diagnosis, • Intraoperative findings, • Description of procedure, • Instrument/pack/gauze count,….etc.		
3	The hospital should ensure women and child friendly services at all MNCH units including pain management. **(0.5 point)**	• Rooms should be well ventilated and temperature of the room should be good (neither hot nor cold): • The rooms should have a working bath room and toilet with door that is accessible to laboring mothers that has a hand washing basin with soap and water for both labor and post-natal ward: • Family member/support person is allowed to remain with woman constantly during labor and birth (interview 3mothers) • Mother is offered oral fluids and light food during labor and allowed to deliver in their preferred position (interview 3mothers • Adequate Pain assessment and management is practiced(check whether scoring pain used as 5thvital sign)		

4	The hospital ensures all equipment, essential drugs, supplies and reference materials are available in maternity and pediatric units **(0.75 point)**	• See annex; MNCH QIassessmenttoolorannex1,2,4,5,6,7,8,&9on MNCH service chapter on EHSTG.		
5	The hospital should ensure the provision of intra-partal care as per national protocols **(1 point)**	• Adequate number of active first stage beds (at least 4 for primary hospitals and 8 and above for general and tertiary hospitals) • Adequate space for walking • Adequate number of second stage couched (at least 2 for primary hospitals and 3 and above for other hospitals) • Well-equipped newborn corner in delivery room (radiant warmer, ambubag# **0/1**, suction materials(bulb & machine), posted basic and advanced neonatal resuscitation flow**chart**) • Midwifes assess and manage the 4 P's for critically ill patients (***Pain, Position, Posy and Possess***) and Pain management for all mothers and children (at least with burn, surgery, Ca). • ***All nursing and midwifery assessment done for all mothers admitted for more than 24hours*** • Chart audit from previous month performance (select randomly 5 MRN fromdeliveryregisterinthequarterandverifyifthefoll owinginformation are available:– • Pantograph filled correctly/ decisions are		

		appropriate and timely, • Delivery summary filled, • Safe child birth checklist filled correctly, • Neonate provided at least with OPV 0/BCG/Vit K, TTC eye ointment)		
6	The hospital should provide comprehensive postnatal care in the facility as per national standards(**0.25 point**)	• Postnatal ward is clean, well ventilated with good temperature (nether hot nor cold) • Chart audit of previous month performance (select 5 MRN randomly from postnatalregisterinthequarterandverifyifmaternalV/Smonitoredevery 30min for first 2hrs and then every 2hr till discharge) • Family planning counseling for all pregnant women with a focus on long term methods •		
7	The hospital should ensure provision of family planning (with focus on long term methods) and comprehensive abortion care services following the national guideline and policies.(**0.25 point**)	• Established CAC unit (separate or with emergency obstetric OPD) • Established FP clinic • Trained health professional were assigned to provide counseling on contraception, unintended pregnancy and abortion; • Demonstrate competent skills and the services should be evidence based: • Comprehensive health and obstetric, gynecologic and reproductive health history taken and physical examination done: • Care, support and referral or treatment for the HIV positive woman and HIV counseling and testing for women who do not know their status provided: • Prescribe, dispense, furnish or administer a broad range of contraceptive methods, including IUDs, implants, injectable emergency contraceptives and women advised about management of side effects		

		and problems with use of family planning methods: • Perform vacuum aspiration (manual or electric) for pregnancies of gestational age up to 12–14 weeks according to the national guideline. • Medical methods of abortion available for pregnancies of gestational age up to 9 weeks, or up to 12 weeks if the woman can stay in the facility until the abortion is complete according to the national guideline; • Clinical stabilization, provision of antibiotics, and uterine evacuation provided for women with complications of abortion; • Referral women who needing unavailable services in the hospital or HCs.		
8	Maternity and pediatric units should undertake CQI activities by conducting regular review meetings and audit programs.(**0.5 point)**	• Regular clinicalauditincludingmaternalandneonataldeathaudi tasper HSTQ that is done monthly, gaps and actions taken • Client/pregnant mothers' forum conducted quarterly (look for minutes, documents, photos etc; verify if action plan prepared and implemented following each forums)		
9	Hospitals have established separate pediatric OPD, emergency and triage services.(**0.75 point)**	• Pediatric OPD is separate from adult OPD • Established separate pediatric triage(*optional for primary hospitals with priority for pediatrics if less case load*) and adjacent emergency treatment area (room) within pediatric OPD and system of triage established before registration • All the necessary human resource trained on ETAT, equipment, drugs and supplies, guidelines and job aids are present (See annex 1 and3) • ETAT is established (select 5 MRN from emergency pediatric register or ETAT register and verify if triage form showing appropriate triage and management is attached)		

10	Hospitals have comprehensive Neonatal Care service that includes NICU, KMC, mother's room and isolation rooms.(**1.5 point**)	• Presence of established neonatal unit composed of at least NICU separate for non-communicable and communicable diseases, KMC room, mother's waiting room. • Neonatal care given by appropriate personnel (neonatologist/pediatrician; in the absence of these, other HCPs may provide the service if they do have special training tailored to neonatal care and problems related to neonates; in which case look for evidences of training or orientation like certificates, training materials etc) • All essential equipment, drugs and supplies present (see annex 2) • All guidelines and job aids present (see annex 3)		
11	Hospitals have separate Pediatric Wards composed of separate critical, general, SAM, isolation and procedure rooms.**(0.75 point)**	• Check that the hospital has pediatric ward separate from adult ward • Check that the pediatric ward is composed of the following rooms: - Therapeutic feeding room for children with complicated SAM - Pediatric ICU or at least HDU for critically ill children next to the nursing station - Isolation room for children with communicable diseases (*in primary hospitals, this may be shared with procedure room for adults*) - Clean, ventilated procedure room with good light source (*in primary hospitals, this may be shared with procedure room for adults)* • All ward room paintings are child friendly • Confirmthepresenceofnationalguidelinesandjobaid slistedinAnnex3, and supplies and equipment listed in Annex 6 are available and functional • From 3 charts in the quarter, check the following: - Children admitted to the wards are evaluated by physicians (preferably pediatricians) on daily basis (twice per day for critical children)		

		- Critically sick children are evaluated by registered clinical nurses every 4hours • Vital signs are measured every 6 hrs. for admitted children(more frequently if ordered by a physician) - Growth monitoring is performed for *all U5* children admitted to the ward • Admission and discharge notes, vital sign sheets, and discharge or death summaries are attached to the patient charts • Nutritional screening for ***all age*** groups according to the guideline • Pain management at least those with burn, surgery, cancer		
12	Midwives should implement the midwifery process at all hospitals for all admitted patients.**(0.5 point)**	• Chart audit from previous quarter (select randomly 5 C/S charts from deliveryregisterand5MRNsofhighriskmotherscare dinmaternityward from admission discharge register and verify if midwifery process was done for all charts (note that midwifery process form is as per EHSTG • nursing/midwifery process format)		
		Total		

CHA PTER 9. LABORATORY SERVICES MANAGEMENT (9 point) **Description:-*Laboratory services strengthen the practice of modern medicine by providing information to end users to accurately assess the status of a patient's health, make accurate diagnoses, formulate treatment plans, and monitor the effects of treatment.***				
S. N	**OPERATIONAL STANDARDS**	**VERIFICATION CRITERIA**	**Met**	**Unmet**
1.	The hospital has a clear laboratory management structure and accountability arrangement with well- defined roles and responsibilities for the provision of laboratory services organized into central, emergency and inpatient laboratory services.**(0.75 Point)**	• View organization chart, clear JD of the department and individuals set by the hospital with customization. • Check assignment of full time quality and safety officers • Check central laboratory controls laboratory services in each department (minutes, reports,..) • Check laboratory staff competence assessment management structures set in the hospital • View central, emergency and inpatient laboratories functionality: ✓ Check 5 randomly selected OPD lab. Requests done during working hrs. on the day of Order ✓ Check 5 randomly selected emergency lab. Requests from ER registration that is done during emergency hrs. in ER laboratory ✓ Check 5 randomly selected IPD laboratory requests done at IPD lab. on the day of order		
2.	The hospital laboratory management has established system for management of documents and records that are maintained, controlled, reviewed and approved to ensure the provision of quality laboratory services.**(0.75 Point)**	• Obtain evidence for document and record generation, identification, approval, use, control and disposal procedure ***with practice*** • View the laboratory-produced ***updated*** quality manual, safety manual, sample management guideline ***with practice,*** • ConfirmtheavailabilityofstandardoperatingproceduresforallTechnical and Managerial procedures in all service areas at workplace • Confirm the availability of ***updated*** Guidelines, Formats , Job aids and instructions in workplace • Check all Lab. staffs involved in preparation of all necessary documents		
3.	The hospital laboratory has established system to monitor the effectiveness of its customer service program.**(1 Points)**	• View pocket sized clinicians' laboratory handbook in all services areas with updates (check all tests included). • View customer satisfaction survey report and implementation of identified gaps		

		• View presence of suggestion box to collect customers suggestions that are analyzed regularly • View documented and updated post of available/discontinue test menu with current price implementation practice • TAT to customers. (check TAT monitoring systems) • Confirm the laboratory staffs communicated the available tests to their clients with advisory service • Advisory services for HWs recorded, panic results identified and communicated with HWs to urgent actions • CheckwhatactionstakenonessentialLab.testsunavailability(*Laboratory KPI*) by hospital		
4	The hospital laboratory has and implements a proper management system for its equipment that includes the calibration, maintenance and inventory to ensure the provision of accurate, reliable and timely test results. **(0.75 Point)**	• Check laboratory M/Es inventory list updated Lab. department conduct preventive and corrective maintenance for all M/Es as per manufacturer recommendation • Check updated SOPs availability(Operational, Preventive maintenance) job aids, forms,… for each M/Es at each department • Obtain evidence on equipment management system include ways of participation on consultation, selection, specification, installation, calibration with verification plan and performance, maintenance, retiring and disposal		
5	The hospital has a laboratory supplies management system.**(0.75 Point)**	• Confirm the laboratory have functional inventory system for supplies' management • View laboratory has mini store for lab supplies and reagents that should be clean, safe and well ventilated with regular room temperature monitoring • View Bin cards are used to manage laboratory supplies and reagents (check 5 randomly selected bin to update) • View IPLS timely stock status reports and distributions system by service areas and departments		
6	The hospital laboratory shall implement a process control system that monitors the processes from pre analytical to post analytical phases of testing, including an established internal quality control. **(1 Point)**	**Pre-analytical :** • View well established and isolated sample collection area. • View sample collection manual ready for use in workplace. **Analytical phase:** • Obtain records of valid IQC for all tests in regular manner		

		• Confirm whether the laboratory participates in any recognized EQA (PT scheme) or intra laboratory evaluation and scored ≥80% for tests included in that scheme. • Check IQC and EQA out comes evaluated regularly with Lab. staffs and SMT with actions for gaps • Lab. staffs forum with clinical staffs at least quarterly to improve services and Pt., care **Post-Analytical :** • Confirm a system to review results before release independent of testing personnel • View a TAT established for every test and evaluated regularly		
7	The hospital laboratory has established incident handling and reporting system which includes errors or near errors (near misses).**(0.5 Point)**	• View records of occurrences or incidences • View deviations identified and actions taken for improvement and prevent recurrence		
8	The hospital has established laboratory managementinformation system.**(0.5 Point)**	• View written procedure for the laboratory information management system (check for staff awareness with practice) • Confirm the system prevents patient data loss or proves confidentiality, accessibility, accuracy, timeliness, security, and privacy of patient information.		
9	The hospital laboratory should be designed and organized at least for bio safety level 2 or above and work environment is clean and well maintained at all times.**(0.75 Point)**	• View if The hospital laboratory have enough working space • Ensure a laboratory safety program is in place and performed accordingly make sure availability of safety equipment and supplies (first aid kit, spill kit, fire extinguisher, and emergency shower, eye wash, PPE etc) • Interview selected lab staff in order to check relevant safety awareness among staff • Observe for restricted access when work is in progress • Work stations ,floor and walls are easily cleanable,		

10	The laboratory shall design a backup laboratory Service through availing back laboratory equipment or and through backup laboratory facility. **(0.5 Point)**	✓ Confirm if a system designed for back-up laboratory service(*M/E, electric Power, supplies)*
		✓ View developed and signed MOU by all responsible bodies
		✓ View lists of facilities for backup laboratory services for:
		    ✓ Actual performances to reduce service delay
		    ✓ Collaborative review of services by the backup facility
		    ✓ Actions taken to improve
		✓ View back-up (water, equipment, electric power, supply) made ready by the hospital		

11	The hospital laboratory has appropriate storage and stock management systems for blood and blood products received from blood banks. **(0.5 Point)**	• View the mini blood bank • Obtain list of transfusion committee members and focal person with their official letters • Obtain singed MoU b/n hospital and nearby Blood Bank • Obtain equipment inventory list and check their functionality status for mini blood bank • View documents and records for blood received ,blood issued and compatibility test • Check committee performance as per the plan and SOP • Clubs established, Campaign conducted…		
12	The HTC in collaboration with respective regional blood back service shall have mobilization of blood donation strategy through community awareness programs.**(0.25 Point)**	• Obtain number of awareness creation program in the year • View the list of identified potential blood donors by HTC • Identify notification letter written to blood bank to conduct blood donation campaign • Compare ratio of ***collected*** units of blood ***:*** blood ***received*** from Blood Bank in the last year (the ratio should at least > = 1 :1)		
13	The hospital laboratory blood bank service shall have appropriate cold chain system for blood and blood products received from blood bank service until used by prescribers.**(0.5 Point)**	• View SOP for cold chain management system • Randomly check Temperature control chart in the last quarter and done every 6hr • Check regular audits (blood utilization, cold chain Mx) and gaps with actions toward improvement by HTC and SMT		

		• Check the following equipment a. Blood bank refrigerator2-6oc *b.* Blood bank deep freezer <-18oC (*optional for primary hospitals)* *c.* Platelet Agitator 20-24Oc (*optional for primary hospitals)* d. Bench top centrifuge e. Blood group or Cross match plate f. Blood group reagents (Anti-A,B and Anti-D g. Anti-human globulin antisera (*optional for primary hospitals*) h. Biohazard bag i. Blood warmer j. Water bath		
14	The hospital laboratory blood bank services hall report blood administration and patient safety information to respective regional blood banks. **(0.5 Point)**	• View blood transfusion committee performance evaluations and reports address patient safety • Check blood request forms complete to ensure safety • Check whether the transfusion committee evaluate performances and take actions for identified gaps to ward safety • Check all documents are controlled		
		Total		

CHA PTER 10. PHARMACY SERVICES MANAGEMENT (8 point)

Description:-*Pharmacy service is the last and critical step for clients' services in hospitals through appropriate selection, quantification, procurement and rational use of pharmaceuticals that is designed to assure that quality and safety is maintained at all stages of services.*

S. N	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1.	The hospital provides quality pharmaceutical products and effective services in its outpatient, inpatient, and emergency pharmacy service units.**(0.75 Point)**	• Check department and individuals' customized JD, plan with implementation • Presence of separate 24 hr. outpatient, inpatient, emergency pharmacy service • Drug supply management; DSM, Drug information and compounding pharmacy service provision units. • Presence of separate store for medicines and other supplies and reagents. • Check availability of prescribed medicines (pharmacy KPI)and actions taken by the DTC and Management		
2.	The hospital has a functional Drug and Therapeutics Committee (DTC) that develops and implements interventions promoting the rational and cost- effective use of medicines.**(0.75 Point)**	• Presence of DTC annual plan and implementations for the fiscal year • Presence of terms of reference (TOR) and adherence • Presence of official letter of assignment for members • Presence of at least 6 signed regular meeting minutes in the last 12 months as per the TOR • Presence of regular performance report of DTC activities of the last fiscal year to relevant bodies		
3.	The hospital has a Medicines Formulary listing all pharmaceuticals prioritized by VEN that can be used in the facility. The Formulary is utilized and updated annually.**(0.75 Point)**	• Availability of annually updated pharmaceutical list or formulary • The list is prioritized by VEN • Check Consultancy/expertize involvement to update and prepare the list • Prepare STG and adherence monitoring by DTC and department at least every 5 years(***drug formulary &/or annual drug list for primary hospitals***)		

4	The hospital ensures execution of good dispensing practices at all dispensing outlets.**(0.25 Point)**	• Dispensing area workflow organized as: Evaluation &Billing □Payment//Processing □Counseling • Presence of waiting area with seats in OPD pharmacies • Presence of signed prescriptions by evaluator and counselor (hint: see randomly selected 10prescriptions) • Presence of records for identified DTPs(OPD,IPD,ER) and measures taken for identified gaps • Presence of report on patient knowledge on correct dosage and satisfaction with actions taken for gaps identified		
5	The hospital implements auditable, transparent and accountable pharmaceutical transactions and services(APTS).**(0.75 Point)**	• Presence of properly recorded and filed prescriptions, sales tickets and registers at dispensaries • Adequate human resource is deployed in each pharmacy services units (hint: based on workload analysis: number of prescriptions and bed size) • Pharmacy premises are arranged so as to keep patient safety and privacy(for patients need special counseling) • Implementation of coding to uniquely identify medicines (service areas, stores) • Bin ownership and updating is implemented • Presence of regular monthly reports for products, finance and services which is evaluated by DTC and SMT with corrective actions • Presence of audit report (internal) with corrective actions • Wastage rate in monetary value is<2% • Presence of annual report on ABC and VEN analyses		

6	The hospital provides clinical pharmacy services at inpatient, outpatient and emergency departments.**(0.75 Point)**	• Completed patient medication profile form, pharmaceutical care progress recording form and medication reconciliation forms are part of the patient chart (hint: see randomly selected 5 patient charts at inpatient ward) • Check Medication reconciliation records, identified gaps and actions taken • Ward pharmacy available at least in major wards and functions for 24hrs. • Unit dose dispensing is implemented at ward pharmacies (medicines are dispensed only for 24hrs.) • Regular participation of pharmacists in ward rounds, death audits and seminars (check with evidences)		
7	The hospital provides drug information services to health care providers, patients and the public. **(0.5 Point)**	• Presence of properly filled query receiving and equivalent responses/actions to clients staffs, general community • Presenceof recently prepared sample drug alert/newsletter, therapy update, and drug monograph. • Presenceofregularupdatesonstockavailabilitytotheho spitalcommunity (ask health care team or see records) • Presence of medicine use education for patients (check service areas with evidences) • Well-designed DIC having internet access and all necessary supplies for clients and staffs (***DIS with at least internet access for primary hospitals***) • Has started providing poison information with documented evidences • Presence of survey report on patient satisfaction of overall pharmacy services		

8	The hospital has a functional compounding service. **(0.25 Point)**	• Separate premises for compounding service • Availability of equipment, materials and chemicals • Availability of SOP for all compounding procedures • Recorded documents for all compounded items with revenue generation		
9	The hospital has efficient and effective pharmaceutical logistics management system that reduces the frequency of stock-outs, wastage, over supply and drug expiry.**(0.75 Point)**	• Presence of updated procurement policy • Presence of annual pharmaceutical quantification and supply plan approved/agreed by the team and then by SMT • Report that shows percentage of procured items from the hospital request list. • Presence of updated bin card (check bincards randomly within mini stores and IPLS of service areas with main stores) • Good storage practice is being followed (see annex) • Check actions taken to sustainable availability of drugs and supplies		
10	The hospital has appropriate ***both*** paper andcomputer-based inventory management system.**(0.5 Point)**	• Presence of properly recorded of ***both*** paper based and electronic inventory management tool • Presence of regular physical inventory report of dispensaries for main stores • Presence of stock status analysis report, identified gaps and actions taken		
11	The hospital has an established system for regular . Monitoring medication use and safety. **(1 Point)**	• Confirm List of identified susceptible individuals known by the staffs and monitoring ADRs with actions based on reports • Presence of semi-annual prescription monitoring report and actions • Presence of annual DUE Report and actions • Presence of ADE report and actions • Presence of WHO drug use indicator study report and actions • Presence of update on (high alert medications, error prone abbreviations, look-alike and sound alike medication list…)		

12	The hospital conducts continuous segregation, Documentation and safe disposal of pharmaceutical wastes. **(1 Point)**	• Presence of guide line, SOP for disposal for the hospital products • Presence of list of disposed products with description • Expired medicines are separately segregated • Presence of certificate for disposed medicines (minutes during disposal)		
		Total		

CHAPTER 14. FEDERAL AND TEACHING HOSPITAL SERVICES MANAGEMENT (4 Point)

Description:-Teaching processes in hospital setting are critical to providing high-quality care for patients and provide an opportunity for a coordinated plan of care while facilitating full engagement of the patient and/or care givers in making shared decisions about the care.Clinicalteachersandstudentsneedtounderstandthewiderimpactoftheirapproachestowardcare,whilstmanagersbeararesponsibilitytoensureproperimplementationsofteaching,patientcareandresearchactivitiesinawaythatcanimprovepatientsafety,patientexperience,teamworkand efficient use of resources.

S.No	OPERATIONAL STANDARDS	VERIFICATION CRITERIA	Met	Unmet
1	The hospital has established functional management and governance structure that integrates ***patient care, medical education and research.*** **(1 point)** ***CED – chief executive director*** ***CCD – chief clinical director*** ***CRD - chief research director*** ***CAD - chief academic director***	• View the organogram of the hospital • View clear customized JD prepared for CED,CRD,CCD,CAD • Check the membership that University GB involved in hospital GB • Check strategic and annual plan coordinate the ***three area of services*** • View executive committee plan , TOR with its implementation • Check engagement of physicians in the implementations of the three Service areas (CRD,CCD,CAD)		
2	The hospital implements an ***orientation*** program for students/interns/residents on hospital policies and procedures prior to clinical attachments. **(0.5 point)**	• View the orientation guidelines • Check orientation guide line addresses all areas of topics(EHSTG) given to all students regularly • Interview five students/interns/residents randomly to check if they have taken the orientation before clinical attachments.		
3.	The hospital has established system to ensure care provided and students' practice maintains patients' confidentiality and privacy at all times. **(0.5 point)**	• View protocols for conducting teaching on patients. o Check orientation address about confidentiality &privacy • Interview 10 patient from different wards on their privacy, confidentiality and ***their involvement*** on the care process. • Observe patient care areas for privacy • CRC implementation progress discussed in each department • Check presence of skill labs and simulation centers for practice		

4.	The hospital has established protocols/policies and procedures for ward rounds and bedside students' teaching to maximize patients' benefit. **(1 point)**	• Check for presence of protocol that defines type of rounds (***ward/bedside rounds and Teachings round***) • Interview staff for their knowledge on the protocol and adherence • Check whether student to patient ratio is defined for round • At least departmental daily MDT morning session conducted on critically ill patients • Check Time spent for bedside/teaching round defined & adhered too • On duty physician visit all patients at least during each shift and as necessary for critical patients • Consultant's recommendation on bedside/teaching rounds are implemented and recorded (*if there is*) • Check mechanisms that all findings and recommendations on teaching rounds recorded		
5.	The hospital ensures students/interns/residents' patient care provided is supervised by their respective teachers/hospital based instructors at all times.**(0.5 point)**	• View posted program listing supervisors/teachers for specific unit and for specific date • Beside the students/interns/residents the hospital assigns a staffs (Coordinator) accountable and responsible for all their respective patient care activities at all times. • Check scheduling systems aligned with hospital human resource management system		
6.	The hospital has established guidelines, memoranda of understanding and procedures for affiliation with other teaching institutions, communities and field activities**. (0.5 point)**	• View the guidelines/MoU for affiliation with other hospitals, community, for field activities • Check implementations of the MoU among parties • Check monitoring mechanisms of the hospital management for the implementation of MoU with its stakeholders		
		TOTAL		

CHAPTER 19: CLNICAL GOVERNANCE and QALITY IMPROVEMENT (9 point)

Description:-*Clinical Governance is the system through which hospitals are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence can flourish. It organizes multidisciplinary teams and the involvement of patients.*

Clinical leadership is critical to the success of any hospital that the board & the management together leads the hospital strategy for clinical governance and quality improvement. The CG&QIU team will be available for staff to share experiences, ask questions and offer solutions to colleagues on their day to day quality improvement activity - >'Quality is a moving target and continuous improvement'.

Clinical governance and quality management requires health professionals having up-to-date knowledge (as '*<u>Quality of today may not of tomorrow'</u>*) of the most effective diagnostic tests, treatments and procedures. Therefore all staff in a facility have a responsibility to ensure

S. N	***that all interactions with patients and carers are undertaken with respect for the individuals - >'Quality is everybody's business!!'.***	**VERIFICATION CRITERIS**	**Met**	**UnMet**
1	The hospital has a Clinical Governance and Quality Improvement Unit that is led by at least MPH/MSc or General Practitioner**. (1 Point)**	• The hospital quality unit lead by at least MPH/MSC or General practitioner: • Confirm if there is letter of assignment with customized departmental and individual JD developed and signed • Check QU head is member of hospital SMT • Check department QI team lead by senior physicians (*GP if no senior for primary hospitals*) • Check Quality Committee members' list include physicians from all department • Check plan and TOR prepared, agreed by all members and well adhered • Check QC meeting minutes (Regularity, attendance of members,…) as per TOR • Check the structure for implementation, monitoring and evaluation of QI projects by QU, GB, SMT and departments that all lead by the QU.		
2	The hospital should develop a clinical governance and quality improvement strategy and an operation plan that addresses the key components of quality.**(1 Point)**	• View Clinical Governance and Quality Improvement strategy approved by GB & SMT and ensure that the **strategy includes**: ✓ Safety and risk management ✓ Clinical effectiveness ✓ Clinical Audit ✓ Professional competence using different methods ✓ Patient focused care ✓ Patient and public involvement ✓ Benchmarking ✓ Check if there is annual plan		

		• Confirm that reports regularly received and evaluated by SMT and GB taking 'No. of graduated QI projects' as a major indicator		
3	Procedures are established to monitor clinical practices and standards through services' specific process and outcome measures to enable the hospital to address any problems identified. **(0.75 Point)**	• Check list of clinical outcome measures developed and monitored regularly. o See the most recent results of at least 3 clinical outcome measures and appropriate action based on results to provide safe and quality service. o Confirm with 5 selected staff from clinical service areas whether they are aware of selected clinical outcome measures		
4	The hospital implements a regular clinical audit program in each service area. Such program encourages the participation of all clinical staff and includes the implementation of a quality improvement plan derived from audits.**(1 Point)**	• Check that all relevant clinical service areas are self-audited based on HSTQ • Check the composition of audit team (staff and service users' involvement) from audit reports. • Verify audit reports and an improvement plan (QI project) produced for improvement • Check whether *re-audits* are conducted to close gaps identified during previous audits & check if there is an improvement.		
5	Procedures are established to assess and minimize risk arising from the provision and delivery of health care. A system is also in place for reporting and analyzing incidents, errors and near misses. **(1 Point)**	• View regular ***risk assessment reports*** and actions of inpatient, outpatient, ER case teams, laboratory and other departments at least quarterly • Confirm that the hospital has an Incident Officer who has a job description that outlines his/her duties in relation to incident investigation and management. • View two recent Incident Reports (if any) and confirm that the reported incidents were investigated and any necessary follow up action documented by the Incident Officer. • Confirm that the hospital has a plan to identify, analyze and monitor risks, incidents, errors and near misses with staff involvement from respective service areas		
6	The hospital adopts a statement of patient rights and responsibilities, which is posted in public places in the hospital. **(0.25 Point)**	• View statement of patient rights and responsibilities. • Visit patient service areas (as a minimum OPD, ER and inpatient wards)and confirm that statement is clearly displayed.		

7	The hospital continuously and systematically reviews and improves all aspects of its activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others.**(0.75 Point)**	• Check occupational safety issues lead by QU and work with HR, hospital incidence officer, IPPS focal…… • View strategy in QU that includes identified risks assessed,		
8	The hospital monitors patients' experiences with care through patient and satisfaction surveys conducted on a quarterly basis. **(0.75 Point)**	• View results of last patient satisfaction survey. • Confirm that survey conducted regularly every 3months. • Check and confirm that actions were taken as a results of patient satisfaction survey score • Check actions taken to patient satisfaction improvement		

9	The hospital implements a strategy for the involvement of patients and the public in service design and delivery including procedures to be followed when engaging with patients and the public. **(1 Point)**	• View minute document of the Hospital's Public Forum
		• Confirm that public forums or town hall meetings are conducted at least every quarter with saved audio – visual document with date
		• Check whether the hospital informs the public through
		  ○ Patient information leaflets
		  ○ Poster displays in hospital or community
		  ○ Publications in local press
		  ○ Presentations at public meetings
		• Check and confirm suggestion box is used in the hospital and that suggestions are compiled, analyzed and acted upon.
		• Confirm Community representation on hospital Governing Board
		• View patient and public involvement strategy of the hospital.
		• Confirm (by interview with CEO or Chair of QU) that the following activities have been conducted within the previous quarter:
		  ○ Complaints procedures received versus resolved
		  ○ Establishment of patient groups & meeting conducted with minute
		• Check activities to engage marginalized groups of the community		

10	The hospital develops and implements a strategy to provide patient focused care which incorporates compassion, respect and dignity for patients, effective	• View hospital Compassionate, Respectful and Caring Health care Professional Strategy • View and confirm whether the strategy covers issues about respect and dignity, effective communication, better hotel services (housekeeping, nursing care,		

	communication, better hotel services and involvement of patients in the care delivery. **(1 Point)**	balanced diet (food) services, laundry services) • Check hospital set follow up system for CRC implementation as individual and team • Randomly ask and confirm patients and care givers in ward if patients concerns are taken into account and they are involved in the care delivery.(10 clients from IPD) • Check CRC audit and actions taken to better performance as department and hospital/QU level		
11	The hospital participates in benchmarking activities to learn from and share good practice with other hospitals.**(0.5 Point)**	• Confirm (by interview with CEO or other documented evidence) that hospital participates in benchmarking activities. For example regional hospital meetings; • Check and confirm that the hospital attends EHAQ Cluster meetings • Check and confirm with selected hospital staff that they are well aware of EHAQ Change Package		
		Total		

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Section III (b): Selected Data Quality and DHIS 2 Audit tool (10%)

Description: Data quality is very important for robust evidence generation which can be used for operations, decision making, planning and reflect real value or true performance and meet reasonable standards when checked against criteria for quality. If the discrepancy described under each data source is <10%, award "5 point" and >10%, award "0 point".

No	Selected Indicators	Value out of 30	Score	Data source	Remark
1	% of EHSTG standards meet	5		Randomly selected quarter DHIS2 reported EHSTG versus EHSTG hard copy report (EHSTG Assessment hand book)	
2	ER attendances length of stay greater than 24 hours	5		Randomly selected quarter DHIS2 report versus hard copy report from registry (ER Registry)	
3	Delay for elective surgical admission	5		Randomly selected quarter DHIS2 report versus hard copy report from registry (Liaison registry)	
4	Institutional Maternal mortality	5		Randomly selected quarter DHIS2 report versus hard copy report from registry (Admission/Discharge register; Delivery register; PNC register; OPD register; Emergency register)	
5	Bed occupancy rate	5		Randomly selected month DHIS2 report versus calculated at audit time (Liaison Registry)	
6	Patient satisfaction	5		Randomly selected DHIS2 report versus calculated hard copy survey report as per the HPMI Guideline	

Section III c : Saving life through Safe Surgery (SaLTs) Audit tool

Description: SaLTS initiative has been developed to ensure the delivery of quality, safe, essential and emergency surgery to alleviate burden of diseases, disability and death that are preventable throughout safe surgery.

Saving lives through Safe Surgery (SaLTs) (15%)

S1. The Hospital has appropriate and functional working environment to provide quality surgical services. (14 Points)				
Standard and criteria	**Yes / No**	**Score**	**Data Source**	**Remark**
C1. Continuous 24/7 electric supply with automatic backup generator is available.		1	Interview OR staff / Observe the backup generator	
C2.Continuous 24/7 water supply with back up source is available.		1	Interview OR staff /Observation/Testing/	
C3. Minimum number of OR tables are present.		1	Observation	• 1 for primary hospital • 4 for general hospital • 7 for specialized hospital

C4. Cleanliness of the OR room and Equipment's		2	Observe floors ,walls and over all physical structure of the OR room for cleanness Floors of the OR are non-slippery surface and even. Observe for cleans of the OR equipment's OR Table, OR light , Anesthesia machine. Patient Monitor and other machine Separate space for scrubbing and hand washing facility Observe Availability of disinfectants, soup and anti-septic Availability of waste bins and other IPC equipment's and supplies	
C5.Demarcated 4 zones present		1	Observation (restricted, semi restricted, transitional, non restricted).	
C6.Changing rooms with lockers present		1	Observation (separated for male and female, for a minimum of 10 persons).	
C7.Recovery room is present		1	Observe and check for availability of functional beds patient monitor and designated assigned staff	
C8.Toilet and showers present		1	Observe and Check for cleanness (availability of water, tissue and soap)	
C9.OR Nurse station present.		1	Observe for demarcation	
C10.Mini-store present.		1	Observe for stored drugs, supplies	

			and locker	
C11.Safety of electrical establishment		1	Observe and looks for no temporary connections and no loosely hanging wires	
C12.Windows/ ventilators if any in the OR are intact and sealed.		1	Observation	
C13. Privacy kept for all clients throughout all aspects of care.		1	Observe the presence of curtain, designated space for clients Separate space for IV opening, Catheterization	
S2. Adequate staff is consistently available to provide routine care and manage complications (5 Points)				
C1. Number of minimum OR staff available based on the standard.		2	HRIS data base Look for the Pay roll & time sheet	**Primary hospital** – 1 IESO, 2 anesthetist (nurse anesthetist) and 5 scrub nurses. **General hospital** – 2 General surgeon, 1 orthopedist , 4 Anesthetist, 10 Scrub nurses **Specialized hospital** – 3 General surgeon (1 subspecialist), 2 orthopedic surgeon, 3 obstetricians, 1 anesthesiologist, 10 anesthetists, 20 nurses
C2. A clear communication plat form is present to reach staff on duty at all times.		1	Look for A roster is used which is accessibly displayed in all areas, detailing the names of staff on duty, the times of their shift and their specific roles and responsibilities.	

C3. A written, up-to-date quality-of-care improvement plan and patient-Safety program is present in OR and surgical ward.		2	Document review , OR Head and Staff interview Monthly meeting is conducted to review data, monitor quality improvement performance (e.g., a dashboard of key metrics)	
S 3 Surgical service leadership and efficiency (8 Points)				
C1. Leadership structure, indicating roles and responsibilities		1	Letter of appointment A written leadership structure, indicating roles and responsibilities	
C2. Availability of client compliant handling mechanisms		1	Look for documents , protocol's , client interview	
C3. Monitor Major surgeries per table per day in the facility		2	Document review Minute, Action taken (last 3 months)	
C4. Monitor Delay for elective surgery		2	Document review Minute, Action taken (last 3 months)	
C5. Monitor Rate of cancellation of elective surgery		2	Document review Minute, Action taken (last 3 months)	
S4 Evidence-based care is provided for all surgical patients. (10 Points)				

C1. Protocols for transferring and consultation mechanisms are present.		2	Document review Interview staff observation Established procedure of handing over is present while receiving patient From OR to wards and intensive care unit (transfer form documented).	Elaborate merge
C2. Antibiotics used for surgical prophylaxis are as per standard treatment Guidelines (STG) recommendation.		2	Chart review Take 10 randomly post-operative charts	
C3. Surgical safety checklist is used.		2	Chart review Take 10 randomly post-operative charts	
C4. Completeness of surgical patients' clinical records		1	Chart review Take randomly 10 charts of surgical patients and look for completeness of patents clinical record including pre, intra and post op assessments and summery notes	
C5. Patient and/or attendant is informed about clinical condition, surgical finding and treatment provided.		2	Client interview Take randomly 5 patients and attendants ask them if they were informed about the clinical condition and its out come	
C6. Check post-anesthesia status is monitored and documented.		1	Chart review for Vital sign monitored four times for the first one hour at least ten charts of post-operative patients	
S5. Availability of essential pharmaceuticals and diagnostic surgical service (8 Points)				

C1. Availability of vital, and essential drugs and supplies for anesthesia and surgical care		2	Check the availability of the list of drugs Client interview	Inhalational general anesthesia IV sedation anesthesia (Ketamine, Midazolam, Propofol) Spinal anesthesia Regional anesthesia available Peri-operative antibiotics IV fluids Muscle relaxants/paralytics Sedatives Vasopressors Post-operative narcotics
C2.Continuous availability of basic laboratory and pathology services for surgical patients		2	Check the availability Client interview	Hemoglobin testing Full blood count testing Coagulation profile testing (PT, PTT, BT, INR) Electrolytes testing BUN and creatinine testing Infectious panel testing (HIV, hepatitis virus, others) Cardiac marker testing Cross matching for blood and blood components
C3. Continuous availability of basic radiology service		2	Check the availability of the list of drugs Client interview	X-ray machine Ultrasound
C4. oxygen is consistently and adequately available in the OR		2	Check oxygen is available in the OR for the last three months.	

Section III (d): Pain Free Hospital Initiative Audit tool

Description: Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage. So PFHI has been introduced to manage the pain strategically at health care service delivery point.

Pain Free Hospital Initiative (5%)

Standard and criteria	Yes / No	Score	Data Source	Remark
S1. Hospital has implemented pain as a 5th vital sign.		**3**		
C1. Pain score is integrated with patients vital sign chart)		1	Chart review on vital sign sheet (10 cards from 5 department randomly)	
C2. Patients Pain assessment is performed, scored and managed		2	Chart review (10 cards from 5 department randomly) scored and managed	
S2. **Hospital has written and approved Pain Management Protocol**		**3**		
C1. Adult and pediatric Pain Management protocol is available		3	Check protocol	
S3. Patients are counseled for appropriate reporting of pain and proper utilization of pain medication.		**3**		

C1. Patient education is given on how to report pain and proper utilization of pain medication.		3	Check hospital regular program for patient education from registration book Interview 5 random patients	
S4.Hospital ensures availability of essential pain medications		**3**		
C1.Pain Medication included in the Vital List.		2	Review medication vital list and Check availability of pain medications (Non-opioids, weak Opioids or Opioids).	
C2. Hospital pharmacy department promotes Good Dispensing practice for pain medication.		1	Interview random Patient and staff.	
S5. Hospital has conducted regular pain assessment and management audit.		**3**		
C1. Hospital conduct a Pain Assessment and Pain Management Audit		1	Review quarterly audit report (for the last two quarter).	

C2. Clinical audit result analyzed and an action plan is prepared.		2	Observe analyzed audit tool Review prepared action plan.	

Section III (e): CLUSTER ACTIVITY (EHAQ Networking and engagement) Audit tool

Description: The Ethiopian Hospital Alliance for Quality (EHAQ) is a system for promoting learning and collaboration, based on a model that involves hospitals exchanging knowledge with each other and empowering the hospital industry to self-improve.

CLUSTER ACTIVITY (10%)

Note: all standards will apply for all hospitals except standard 1& 2 which will be used only for lead hospitals validation

AUDIT TOOL FOR CLUSTER ACTIVITY AND COMMUNITY ENGAGEMENT- Total score -10%				
S1. Clusters have regular meeting 8	**Yes /No**	**Score**	**Data Source**	**Remark**
C1. There is approved TOR and shared with all members of the cluster		2	Check approved TOR document	
C2. There is agreed activity plan and performance report for cluster.		2	Check approved plan activity Performance report	
C3. Cluster regular meeting is conducted, recorded and follow-up action plan is developed		2	Check the meeting minute at least three every three months Interview technical expert	
C4. Best practices are documented and shared among member hospitals		2	Check availability of documented best practices Interview member hospitals	
S2. Cluster conducts regular mentorship and supportive supervision		**10**		
C1. Lead hospital conducted regular mentorship or supervision to member hospitals.		3	Document review Interview member hospital	
C2. Regular feedback is given to member hospitals		3	Check availability of written received feedback	

			Interview member hospital	
C3. Lead hospital regularly monitored member hospitals cluster performance		4	Check performance report Interview member hospital	
S3 Community discussion panel		**4**		
C1. Quarterly community forum is conducted		2	Check the minutes Interview community representative	
C2. Community forum action plan developed, communicated and implemented		2	Check the action plan and performance report Interview community representative	
S4 Hospital to health centers support		**8**		
C1. Hospital conducted regular mentorship or supervision to catchment Lead health centers.		3	Check performance report Interview Lead health centers	
C2. Hospital regularly monitored performances of Lead health centers		3	Check performance report Interview Lead health centers	
C3. Hospital regularly supported Lead health centers with human resource, medical equipment and supply		2	Any evidence of support (e.g Letter, model invoice) Interview Lead health centers	
			Total score for cluster activity	**30**

SECTION IV: AUDIT SUMMARY

Noted Challenges
Noted Recommendations

Section V: Ethiopian Hospital Alliance for Quality (EHAQ) 3rd Cycle Audit Auditors Quick Guide

1. **Pre-Audit**
   a. Site specific audit plan prepared
   b. Establish central coordinating team
   c. Form audit team at national level
   d. Logistics preparation and communication
   e. Training on audit process and tool for the selected audit team
   f. **Pre-opening Meeting**- Audit team leader ensure that EHAQ audit team has site-level verification checklist/audit tool and supplementary materials (In the form of Hard copy and Soft copy).
   g. **Opening meeting**-detail brief on the overall audit process with the Management team
2. **During Audit**
   a. Apply Audit techniques as follows: Auditors complete this audit using the following methods to evaluate the verification criteria under each standards:
      i. Interview: interview health care professionals, administrative staff and clients when applicable
      Note: Ask open ended questions to clarify documentation seen and observation made by asking questions like "show me how..." or "tell us about…."
      ii. **Document review**: review the necessary/applicable documents to verify that Guidelines, Manuals, SOPs are complete, current, accurate, and periodically reviewed.
      iii. **Record review:** review implementation evidences such as patient card/charts, maintenance record, reports, improvement records, registers/logs, and survey and inspection records retrospectively with the defined time frame. Write deficiencies and non-conformities identifies are adequately reviewed, investigated and resolved/corrective action taken within established time frame.

EHAQ

iv. **Visual observation**: observe the hospital operation process to ensure that it follows written guidelines, policies, procedures. Write deficiencies and non-conformities identified are adequately investigated and resolved within established time frame.

b. Consider the following definition of terms during the audit

i. **Adequately**: satisfactory or acceptable in quality or quantity against a reference measurement

ii. **Regularly:** with a constant or definite pattern or a uniform interval of time

iii. **Properly**: correctly or satisfactorily or exactly against a reference measurement

iv. **Random**: selected without method or conscious decision

v. **Observe**: active acquisition of information from a primary source or it involves the perception and recording of data using data sources/indicators.

vi. **Interview**: meeting/asking individuals/team face to face

vii. **Verify**: make sure or demonstrate that the evidence is true, accurate, or justified

viii. **Queue Management System**: a system implemented to control queues

ix. **Effective communication**: when the information communicated between hospitals accurately transferred, received and interpreted.

x. **Monitoring system**: a system used to monitor activities and performances routinely

xi. **Preventive Maintenance**: a type of maintenance performed in a scheduled manner regularly before any failure happened

xii. **Corrective/curative Maintenance**: a type of maintenance performed by service engineers or trained personnel after failure is noted and reported

xiii. **Functional and Consistent Operation**: is an indicator for a system, instrument, software, or utility working as intended to be without interruption or failure

EHAQ

xiv. **Availability:** the required item is being able to be used or obtained or accessed

xv. **Visibly clean:** means that all surfaces in an area designed to be cleaned when viewed from any other area is seen to be free from all debris, dust, fluff, stains, soiling, water, fluids, and other unwanted materials

c. Scoring

i. EHAQ Checklist contains main sections, standards and verification criteria. Each item has been awarded specific point value based upon relative importance and/or complexity.

ii. To give score, assess each requirement and take account of objective evidence. Please circle or make a tick mark as relevant Yes (Y), or No (N) or Not Applicable (NA)

iii. Items marked "Yes" receive the corresponding point value. All elements of a question/verification criterion must be satisfactorily present in order to indicate "yes" for a given item and thus award the corresponding points.

iv. Items marked "No" receive 0 point.

Note: When marking "No", notes or explanation should be written in the "Remark" field to explain why the hospital did not fulfill this requirement to improve the hospital by addressing these areas of identified need following the audit.

v. The total audit score will be calculated as follows:

$$\text{Total Audit Score Percentage} = \frac{\text{total score X 100}}{300}$$

vi. Where the checklist question does not apply, indicate as "NA". Subtract the sum of the scores of all questions marked "NA" from the total of 300. Since denominator has changed, the overall score is then determined using % score.

EHAQ

3. **Post-Audit**
    a. **Pre-closing Meeting**: Audit team gathers and evaluate the process and ensure the Audit is completed (verify the completeness of audit checklist, analyze and reach to conclusion) as per the plan through the audit team leader chairmanship.
    b. **Closing Meeting**: Conduct closing meeting with the Management. The main purpose of the meeting is to acknowledge the cooperation and participation of the Hospital throughout the audit process. Note that in this meeting there must be finding disclosure.
    c. **Compile, sign, pack, and submit the report to the central team.**
4. **Guiding Principles**
    a. Confidentiality
    b. Emotional intelligence
    c. Clear and precise communication
    d. Respecting auditee
    e. Professional judgment
    f. Integrity
    g. Objectivity
    h. Punctuality
    i. Denying any gift

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