Report on the

Expert group meeting on hospital accreditation

Cairo, Egypt
23–26 September 2002
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1. INTRODUCTION

An intercountry Expert Group Meeting on Hospital Accreditation was organized by the World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) in Cairo, Egypt, from 23 to 26 September 2002 to discuss implementation of a process of hospital accreditation in countries of the Region. Participating countries were Bahrain, Egypt, Jordan, Kuwait, Libyan Arab Jamahiriya, Morocco, Oman, Pakistan, Saudi Arabia, Syrian Arab Republic and Tunisia. The meeting had the following objectives:

• Exchange information and opinions among the different participants with a view to building a regional consensus on the relevance, usefulness, and feasibility of the proposed accreditation programme.

• Review the draft WHO/EMRO manual on hospital accreditation.

• Advise on implementation, at the national level, of a process of continuous improvement of the quality of care through the periodic accreditation of hospitals, with the establishment of a multi-institutional National Hospital Accreditation Commission.

The meeting was opened by Dr Mohamed A. Jama, Deputy Regional Director, WHO/EMRO, who delivered a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean Region. In his message, Dr Gezairy highlighted the pressing need for a highly recognized quality improvement and accreditation process as a result of the national health reform policies in various countries of the Region. He explained that hospital accreditation in the Region was a method of ongoing consensus, rationalization, and hospital organization and that the expert meeting would be helping to develop the first instrument for the explicit and objective technical evaluation of quality, the accreditation manual. He stressed that the national response, in the form of creating the national accreditation body, was of great importance. Such an entity should be apolitical, multi-representational, and should undertake its work energetically, prudently and periodically. This entity would be responsible for the administration and policy-making of the accreditation system at the country level. It would be responsible for the setting of national standards for accreditation, adopting WHO guidelines for accreditation, identifying and training the surveyors, conducting and monitoring the site surveys and making the decisions related to the awarding and maintaining of accreditation. Dr Gezairy concluded by emphasizing that this national ownership was crucial for laying the foundation and for maintaining, from the beginning, a high degree of integrity and accountability of the national accreditation system.

Dr Ahmed Abdullatif, Regional Adviser, Health Care Delivery, WHO/EMRO, described the meeting objectives and expected outcomes. The first objective was to exchange information and opinions among participants with regard to the proposed accreditation programme. The second was to review the draft EMRO manual on hospital accreditation and the third objective was to give advice on implementation of accreditation at national level. Three outcomes were expected from the meeting.

• Proposed revisions to and comments on the draft manual on hospital accreditation.
Proposal of a chronogram with follow-up activities on hospital accreditation.

Proposed recommendations for specific actions for the promotion of hospital accreditation in countries of the Eastern Mediterranean Region.

Dr Mohamed Mofti was elected Chairman. Dr Mahi Al-Tehewy was elected Rapporteur. The meeting agenda, programme and list of participants are included as Annexes 1, 2 and 3, respectively. Annex 4 is the draft regional accreditation manual.

2. TECHNICAL PRESENTATIONS

Dr F. Siem-Tjam, Technical Officer, Health Service Provision, WHO/HQ, introduced accreditation issues and trends. He discussed the advantages of accreditation and differentiated between licensing, accreditation and certification. Other ongoing initiatives in this field included an accreditation project for countries in South America and Caribbean (1990–1997) and initiatives in several countries such as India, Malaysia, Philippines, South Africa, Taiwan and Thailand.

Dr Fariba Al Darazi, Regional Adviser, Nursing and Allied Health Sciences, WHO/EMRO gave a briefing on previous WHO accreditation meetings (see reports WHO-EM/HCD/007/E/L/ and WHO-EM/HCD/034/E/L). An intercountry consultation on accreditation of district health facilities was organized by the Regional Office in Limassol, Cyprus, in September 1999. The Cyprus meeting concluded that although the introduction of accreditation of health facilities is desired in the Region, it is not yet developed in its Member countries. The meeting emphasized that in order to initiate question and answer programmes to improve care, it is fundamental to take the following into consideration:

- Leadership commitment. Commitment is needed from the health care leadership to provide the policy support necessary to carry out these initiatives and to be active advocates for their effective implementation.
- Regulation. To implement accreditation, there have to be specific regulations promulgated in the countries if this system is to be taken seriously by the health facilities and the health care teams.
- Resources. Allocation of adequate resources, both human and physical, is crucial for the sustainability and institutionalization of QA.
- Use of data. Facilitating the use of data in improvements and decision-making is another formidable challenge. In addition, issues related to data availability, access, quality and usefulness need to be addressed.
- Sustainability. Institutionalization of the QA system is fundamental to the future of this initiative in the Region. Therefore identifying the right motivating factors and the
mechanisms for using incentives to encourage QA innovation and proactive involvement is crucial for the QA to sustain itself and succeed.

In April 2001 the Regional Office, in collaboration with Health Ministers’ Council for Gulf Cooperation Countries, held a consultation on accreditation of district health facilities in Riyadh, Saudi Arabia. Recommendations of the meeting were as follows:

- Institutionalize quality improvement and accreditation through creation of a quality culture by raising awareness, seeking political commitment, preparing a policy document, establishing adequate structures and processes, building partnerships and mobilizing required resources.

- Establish a critical mass of expertise within countries by integrating quality improvement and accreditation concepts in both basic and in-service training programmes for continuous professional development.

- Adapt and implement the regional guidelines for accreditation.

- Introduce a system of reward to recognize achievements in performance improvement at all levels.

- Prepare and regularly share with other countries reports on national experiences and models of quality improvement and accreditation for advocacy and networking in the Region.

Dr Abdullatif presented an introduction to the regional accreditation programme. The programme has three primary purposes:

- Strengthen the role of the national health authority through a progressive structured and scientific process for appraisal based on quality care standards that ensure accountability of the national health system policies and strategies.

- Develop a system for continuous improvement of services, where facilities play an active role in monitoring and improving their performance.

- Prepare all interested public and private facilities for their new role in health system development.

In his presentation, Dr Abdullatif also discussed three perspectives of accreditation, accountability, educational and recognition.

Dr Novaes, WHO Consultant, presented the concept of hospital accreditation and its application. He emphasized the interdependency of different parts (departments) of the hospital. He also discussed some quality initiatives and compared industrial quality with quality of health care. He elaborated many reasons in response to the question “Why Accreditation”. In reviewing the history of accreditation, it was emphasized that the United
States of America invested about 20 years to move from basic to optimum standards and another 20 years to establish standards by function. A few more years were also invested to focus on outcomes of clinical practice.

Dr Siem-tjam gave a presentation on the experience of South Africa. He emphasized that in this surveying experience in itself did not necessarily improve hospital performance. However, accreditation (role of facilitator) had positively improved the performance.

Dr Noves introduced the draft accreditation manual. He began by defining structure, process, and outcomes and characteristics of standards. He introduced the concepts of levelling in setting standards, and of voluntary, confidential and periodic accreditation. He also compared the idea of accreditation on a “yes” or “no” basis versus scoring. During discussion about the term “qualitative indicator”, Dr Novaes explained that it is evidence of performance rather than indicator. Criteria of surveyors were also discussed, and the link between the Arab Board and the hospital accreditation programme was discussed. At a later stage there will be a need to coordinate the efforts between the Arab Board accrediting teaching and training hospitals and the service oriented hospitals of the Eastern Mediterranean Region.

Dr Abdullatif gave a presentation on the accreditation process in countries of the Eastern Mediterranean Region. He proposed ten steps to launch the accreditation process at the national level and nine steps at the local (hospital) level. A plan of action for hospital accreditation at the country level was then proposed, specifying the task, purpose, activities and time-frame needed. The revised versions of the steps at national and local levels, as well as plan of action, are presented in Section 6 (Group Work).

3. COUNTRY PRESENTATIONS

3.1 Bahrain

Bahrain currently provides comprehensive health services to the entire population in line with the WHO global objectives of health for all. Most health care services are provided by the Ministry of Health through 21 primary health care centres and clinics, Salmaniya Medical Complex (900 beds), psychiatric hospital (201 beds), geriatric hospital and four maternity hospitals (68 beds).

Health care is also provided by the Bahrain Defence Force Hospital, which is managed by the Ministry of Defence. The Hospital provides services to a large section of the population. A number of highly specialized services are offered and the Sheikh Mohammed Al-Khalifa Cardiac Centre provides advanced cardiac care services to all of the population in Bahrain.

According to the Office of Licensure and Registration data, there are currently three private hospitals in Bahrain:
• Bahrain International Hospital. It was inaugurated in 1978 and has 100 beds, including maternity facilities and an in vitro fertilization centre.

• American Mission Hospital. Established in 1902, it has a current capacity of 40 beds as well as an extensive dental service.

• Awali Hospital. Established in 1937, it provides medical, surgical, obstetrics, gynaecology and dental service to employees of the Bahrain National Oil Company and their families. It has a total capacity of 37 beds.

In addition, a number of other hospitals have been established recently, such as the Ibn-Nafees Medical Complex with 11 beds and Gulf Dental Specialty with 10 beds. Several other hospitals are also being planned.

As part of developing health strategy, the Ministry of Health undertook a SWOT analysis (strengthens, weaknesses, opportunities, threats) with most of the departments of the Ministry of Health, including clinical and non-clinical areas. Strategies for the future will focus on capitalizing on the strengths while trying to eliminate or reduce the impact of weaknesses. At the same time, strategies will aim at utilizing the available opportunities for the advancement and growth of health services while taking possible threats into consideration in order to remain responsive.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly qualified staff</td>
<td>Open political environment</td>
</tr>
<tr>
<td>Comprehensive range of services</td>
<td>Strategic alliances with other</td>
</tr>
<tr>
<td>Support from top leaders</td>
<td>organizations</td>
</tr>
<tr>
<td>Good infrastructure–advanced technology,</td>
<td>Community participation</td>
</tr>
<tr>
<td>good facilities</td>
<td>Investment in IT</td>
</tr>
<tr>
<td>Strong alliances–local, regional and international</td>
<td>Acknowledged role of service planning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weaknesses</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual role as regulator and provider are often confused</td>
<td>Government control of finance</td>
</tr>
<tr>
<td>Lack of integration, communication and</td>
<td>Demographic changes</td>
</tr>
<tr>
<td>coordination</td>
<td>Unplanned service developments</td>
</tr>
<tr>
<td>Workforce planning</td>
<td>Negative media and unrealistic public expectations</td>
</tr>
<tr>
<td>Financial systems</td>
<td>Private sector attracting staff</td>
</tr>
<tr>
<td>Organizations structure</td>
<td></td>
</tr>
<tr>
<td>Performance management</td>
<td></td>
</tr>
<tr>
<td>Centralized decision-making</td>
<td></td>
</tr>
</tbody>
</table>

There is only one programme which addresses training in health and hospital administration issues, the Diploma for Health Care Management given by Royal College of Surgeons in Ireland in coordination with Ministry of Health Training Directorate. Quality
management is not yet taught as a separate subject, but it is integrated within several courses. There are plans to introduce a Master’s Degree in Health Policy by Arabian Gulf University.

Bahrain is aiming to provide high quality customer services not only in the country but also in the region. Consequently, expectations of service quality from government organizations are becoming greater. A ministerial resolution (no 1555) was issued in October 1999 to establish a performance improvement committee in every government organization with primary responsibility for improving quality services and work performance.

Since the late 1980s there have been a number of quality assurance and continuous quality improvement activities in SMC and primary health care centres. In April 2002, a Quality Council at Ministry of Health was formulated with the aim to implement sustain and facilitate the quality improvement initiative based on directions derived from Ministry of Health mission and strategies. The Office of Licensure and Registration in the Ministry of Health was established in 1986. It is the official regulatory authority for all health professionals and health care organization/agencies in the country. In 2001 the American Mission Hospital introduced a quality management programme as part of preparations for the Joint Commission on International Accreditation (JCIA).

Responses to the questionnaire on accreditation activities in Bahrain

<table>
<thead>
<tr>
<th>Name of your accreditation programme</th>
<th>ISO 9001–2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme name in English</td>
<td></td>
</tr>
<tr>
<td>Address of the programme: Street, PO Box</td>
<td>Bahrain Military Hospital</td>
</tr>
<tr>
<td>City, Postcode</td>
<td>E. Riffa</td>
</tr>
<tr>
<td>Country</td>
<td>Kingdom of Bahrain</td>
</tr>
<tr>
<td>Telephone</td>
<td>766 666</td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Website</td>
<td></td>
</tr>
<tr>
<td>Name of person to contact for this survey</td>
<td>Maj. Sumaya Hussain</td>
</tr>
<tr>
<td>e-mail address of person</td>
<td><a href="mailto:Sumaya_bdf@hotmail.com">Sumaya_bdf@hotmail.com</a></td>
</tr>
<tr>
<td>Is there any law or directive requiring accreditation in your country? Yes/No:</td>
<td>No</td>
</tr>
<tr>
<td>Reference, year</td>
<td></td>
</tr>
<tr>
<td>How is the programme related to MOH/Government?</td>
<td>Independent</td>
</tr>
<tr>
<td>managed by, (partially) funded by, formally Recognized by, totally independent of?</td>
<td></td>
</tr>
<tr>
<td>What year did Accreditation development begins?</td>
<td>1997</td>
</tr>
<tr>
<td>What year was the first operational survey visit?</td>
<td>1998</td>
</tr>
<tr>
<td>Does the programme focus on primary or secondary or tertiary care? All of these</td>
<td>All</td>
</tr>
<tr>
<td>Does it include public and private facilities?</td>
<td>Yes</td>
</tr>
<tr>
<td>Are the accreditation standards available to the public free?</td>
<td>No</td>
</tr>
<tr>
<td>If not, at what price can they be purchased? US$</td>
<td>Differ from one company to another</td>
</tr>
<tr>
<td>Which foreign country most influenced the development of</td>
<td>USA, United Kingdom</td>
</tr>
</tbody>
</table>
Major challenges in the health system are bridging the gap between the available resources and the increasing demand on health services, and managing the growing population and changing demographic structure, which is characterized by dominance of the young population and a rise in the elderly population. Other challenges include ensuring appropriate human resources, supporting and maintaining improved management practices, developing a proper structure and work process and maintaining the availability of advanced technology.

3.2 Egypt

Egypt is a lower middle income country. The economic situation is heavily influenced by the political instability in the region, as well as the need for the country to adapt its economy to the globalization of the world economy. Some 22% of the population is poor. Official unemployment stands at over 10% and is expected to increase to 17% by 2005.

The Egyptian health care system faces multiple challenges to improve and ensure the health and well-being of the Egyptian people. Primarily, there is a double burden of illnesses associated with poverty and lack of education coupled with diseases of lifestyle brought on by economic and demographic transition. High birth rates combined with longer life expectancy also increase the pressure on the Egyptian health system.

Egypt has 2139 inpatient providers located in 26 different types of facility. The total number of beds in these facilities is 123,671. Eighty-eight percent (88%) of all beds in Egypt are in the public sector, with the Ministry of Health and Population having the largest share of
inpatient beds (57%) in the country. In urban areas, the Ministry has 223 inpatient primary health care centres constituting 9.06% of the total inpatient capacity in the country.

The Egyptian health care system is facing serious challenges to enhancing the provision of quality services. These challenges may be divided into five areas: customers, providers, health care organizations, systems and third party payers.

In 1965 the Ministry of Health and Population established a department for monitoring, follow-up and evaluation. This department has the task of analysing the shortcomings and suggesting solutions. In 1993 this department was approved as a General Directorate at the central level, which is replicated at governorate level as departments. A number of quality assurance projects have been implemented, in collaboration with international partners.

- Quality Assurance Project (QAP): a project cosponsored by the United States Agency for International Development (USAID) and established on 1993 in collaboration with University Research Company (URC), Bethesda, USA. This project focused on establishing QA capabilities and systems in 5 pilot hospitals: May 15 and Imbaba in greater Cairo, Shark El-Medina in Alexandria, Kantara Garb in Ismailia, and Kafr El-Dawar in Beheira. The main deliverables of that project were a QA hospital manual, QA policies and procedures, clinical guidelines, and the First National Conference on QA in Health Care in September 1995.

- Cost Recovery for Health project (CRHP), Ministry of Health and Population as a continuation of the previous project, the quality function was elaborated in the CRHP with technical assistance by URC, Bethesda. The project expanded the pilot to cover all governorates. In 1991, this USAID project developed the first national clinical guidelines for family planning services in Egypt. This product was adopted by the Ministry of Health and Population. Health teams working in this area were trained in the Regional Centre for Family Planning (RCT) and its 7 satellites covering various regions.

- Quality Improvement project (Gold Star), Population Sector. Within the POP III-USAID project, family planning quality standards and indicators were developed, communicated, and monitored. FP units achieving a 98% score in relation to the approved standards are awarded with the Gold Star and incentives for the health team.

- Quality assurance functions of the Child Survival project, USAID-MOHP. Within this project, quality standards and indicators were developed for primary health care services covering the dimensions of the project (EPI, ARI, child spacing and nutrition). The project covered all governorates of Egypt throughout its lifespan (20 years).

- Clinical Service Improvement project, Ministry of Social Affairs (MOSA). This USAID project established Reproductive Health and FP centres in all governorates. These centres are based on self-financing mechanisms. Quality standards and indicators of RCT were adapted and communicated to ensure providing high quality service.
• Sporadic quality initiatives in the Health Insurance Organization (HIO), Curative Care Organization (CCO), and Teaching Hospitals Organization. These initiatives are implemented in some hospitals as individual efforts by hospital directors trained by QA.

• Establishment of the Egyptian Society for Quality Healthcare (ESQua) in 1995. ESQua is a unique entity in the region. The mission of ESQua is to mobilize resources and to coordinate scattered efforts aiming at improving quality of national health system.

• Quality Assurance function of the Healthy Mother/Child Health project (HMHC), MOHP-USAID. This project is a continuation of the child survival project. It covers 8 governorates in Upper Egypt. The HMHC developed quality standards, indicators and protocols for child health and safe delivery.

• Establishing the General Directorate of Quality Improvement and Centres of Excellence (QI/CE), Ministry of Health and Population. Abt Associates, through the Health Reform Project (HR), supported this initiative. During 1999–2000, QI/CE, HR, and the Technical Support Office (TSO) of the Ministry of Health and Population developed a pilot accreditation system. The project was implemented in its pilot phase in 3 health centres in Alexandria, then covered 30 more health centres. Efforts are being continued during 2002 to apply a modified tool for hospital accreditation. That tool is still under testing and modification.

Responses to the questionnaire on accreditation activities in Egypt

<table>
<thead>
<tr>
<th>Name of your accreditation programme</th>
<th>Hospital accreditation programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme name in English</td>
<td></td>
</tr>
<tr>
<td>Address of the programme: Street, PO box</td>
<td>Technical Support Office, Ministry of Health and Population, Magles El-Shaab</td>
</tr>
<tr>
<td>City, Postcode</td>
<td>Cairo</td>
</tr>
<tr>
<td>Country</td>
<td>Egypt</td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
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<td>Fax</td>
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<tr>
<td>Website</td>
<td></td>
</tr>
<tr>
<td>Name of person to contact for this survey</td>
<td>Dr Hanem Abdel-Azem</td>
</tr>
<tr>
<td>E-mail address of person</td>
<td></td>
</tr>
<tr>
<td>Is there any law or directive requiring accreditation in your country? Yes/no; reference, year</td>
<td>No</td>
</tr>
<tr>
<td>How is the programme related to MOH/government? Managed by, (partially) funded by, formally recognized by, totally independent of?</td>
<td>Managed by Ministry of Health and Population and funded by international donors</td>
</tr>
</tbody>
</table>
3.3 Jordan

The population of Jordan is 5.4 million (2001). It is considered to be one of the countries that has accomplished big steps towards primary health care, with an infant mortality rate of 28/1000 live births. Immunization coverage is 96%, 96% and 94% for polio, DPT and measles respectively. The life expectancy rate is 68.6 years and 71.1 years for males and females, respectively. The Ministry of Health budget is US$ 193 million (6% of general governmental budget) and the total per capita health expenditure is US$ 133.

Some of the weaknesses in the Jordanian health system are: financial difficulties; shortages in health personnel due to immigration; inadequate salaries; more need for human resource development including continuing medical education (CME) and scholarships;
inadequate information systems; weak commitment to quality programmes and absence of an accreditation system and re-licensure.

The following are considered to be the strengths of the Ministry of Health: emphasis on PHC services including environment, food, diseases, etc.; good managerial level; good relationship with international health agencies; high level of medical technology; cooperation between governmental and private sectors; good capacity for conducting studies; good number of universities and institutions for medical, nursing and paramedical studies, in both private and governmental sectors; and the creation of the higher health council and higher nursing council that will be responsible for the coordination and planning of health in the country.

The Ministry of Health has begun, with the help of some international agencies, to improve its database and information system. A major training programme in PHC is taking place in the country to train all the PHC centre staff on primary health care services (2500 people have been trained to date). In collaboration with WHO and USAID, the Ministry is working on implementation of a CME master plan and accreditation system. A health academy was recently established for teaching health administration.

<table>
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<tr>
<th>Hospitals in Jordan (2000)</th>
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<tbody>
<tr>
<td><strong>Sector</strong></td>
</tr>
<tr>
<td>Ministry of Health</td>
</tr>
<tr>
<td>RMS</td>
</tr>
<tr>
<td>JUH</td>
</tr>
<tr>
<td>JUST</td>
</tr>
<tr>
<td>Private</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health personnel in Jordan (2000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category</strong></td>
</tr>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Dentists</td>
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<tr>
<td>Pharmacists</td>
</tr>
<tr>
<td>Registered nurses</td>
</tr>
<tr>
<td>Midwives</td>
</tr>
<tr>
<td>Assistant nurses</td>
</tr>
<tr>
<td>Nurse-aids</td>
</tr>
</tbody>
</table>

The Ministry, through its directorate of licensure and medical professions, is responsible for licensing all practising professionals in the country as soon as they are graduated, but no further annual re-licensing is needed.
Some hospitals have applied for ISO on a voluntary basis. The Ministry of Health began to implement a quality assurance programme in some of its hospitals in 1993, and serious efforts have been done since that time. This includes development of protocols and guidelines and establishment of different quality assurance committees.

A special Quality Assurance and Monitoring Directorate was created in the ministry, but has come to concentrate on monitoring more than on quality. Some steps are being taken now towards reviving the quality assurance focus.

Accreditation of hospitals or other health care organizations is not yet activated. However, sincere efforts are being made, and many different parties, including the Ministry of Health, are interested in creating an accreditation body.

Regarding training in health and hospital administration, Jordan has established a 2-year master’s degree programme in Jordan University. To date 65 people have been graduated with a master’s degree in hospital administration. This programme stopped for few years, but has been opened again. Some private hospitals teach a 4-year bachelor’s degree in hospital administration. Other universities have short 2-year diplomas in hospital administration.

In collaboration with WHO and Jordan University of Science and Technology, (JUST) a new 2-year diploma in applied administration will begin in 2003. Graduates from this programme will be allowed to continue their study in JUST to obtain their master’s degree.

Major challenges in health systems and hospitals include the following:

- Continued difficult economic situation.
- Lack of cooperation and integration between different health sectors.
- Need for a national health insurance programme.
- Loss of skilled human resources.
- Lack of comprehensive health information system.
- Need for continuing medical education (CME).
- Need for accreditation and re-licensure.

3.4 Kuwait

The health care system in Kuwait is managed by the Ministry of Public Health, the main provider of health care. The system is including primary health centres, secondary care hospitals and tertiary care centres and hospitals. The role of private sector, as health care provider, is limited as health care is given to all the population free of any charge at government health care centres and hospitals. The commitment of the government to improving health status of the whole population is evident and is reflected by the achievements in infant mortality rate, maternal mortality rate, crude death rate and still birth rate.

The infant mortality rate has shown a substantial decrease, from 11.5/1000 live births to 9.1/1000 live births from 1996 to 2000. The maternal mortality rate was 9.6 in 2000 (9.6 per
100,000 live births). The budget of the Ministry of Public Health was about KD 126 per population capita in 1999–2000. Other strengths of the system include well organized management of the care provided by the Ministry of Public Health, awareness about quality of care, community participation in health programmes, well organized health information systems and good rates of health care workforce to population (16 physicians, 41 nurses per 10,000 population at the national level in 2000).

Primary health care services are provided by 75 primary health care centres, each covering about 30,000 people. The total population of Kuwait is 2,189,668 (Ministry of Planning, 2000).

According to the Ministry of Public Health statistics (2000), the total number of Ministry hospitals is 15 (6 general hospitals, one in every health region, and 9 specialized hospitals and centres providing tertiary care). The total number of beds in Ministry hospitals is 4,575 (bed occupancy rate 67.2%, average length of stay 5.3 days). In the private sector there are 5 private hospitals and 3 hospitals belonging to oil companies. The total number of beds in these 8 hospitals is 559 (Ministry of Public Health, 2000).

The other health care organizations are health care centres of Ministry of Social Affairs, Ministry of Interior and Ministry of Defence. However, their share in health care provision at national level is not comparable with that of the Ministry of Public Health, which is the main provider of health care at the national level.

Interest in quality assurance in the health care sector in Kuwait was formalized in 1987, when Quality Assurance Administration was established in the Ministry of Public Health. In 2001 the name and functions of the Quality Assurance Administration were changed to the Accreditation and Quality Assurance Administration (Ministerial order 358/2001). The Accreditation and Quality Assurance Administration is the executive body of the Ministry of Public Health responsible for accreditation and quality assurance activities. At the regional level, quality assurance activities include mortality review, medical records review, utilization review, infection control and accreditation preparation activities.

The Emergency Services Department in the Ministry of Health is implementing an ISO programme. Despite the ongoing activities and initiatives in quality assurance and health care accreditation in the Ministry of Health, the situation in the private sector is still far behind. One hospital is preparing for accreditation by JCIA, others in the private sector are starting quality assurance activities. The rapid turnover of health care personnel, as most of them (89%) are non-Kuwaiti, is an important weakness affecting the implementation of the quality assurance programme.

Licensing of the private sector hospitals, health care centres, laboratories and private clinics is under supervision by Health Licensing Administration of the Ministry of Public Health. Licensing of the organizations is given according to their compliance with standards of licensing of different health care organizations and after being assessed by the health licensing administration. Moreover, all private health care organizations are inspected by teams of professionals assigned to inspect the private sector health care organization to check
their compliance with laws of medical practice. During 2000, the total number of inspections was 724 (413 for private hospitals, and 311 for private clinics). The 2000 statistical report of the health licensing administration showed that the total assessment visits (pre-licensing visits to organizations requesting licensing was 141, with 42 for hospitals, 46 for clinics and 53 for other private places).

The Kuwait Health Care Accreditation Programme (KHCAP), established by Ministerial Order 358/2001, is totally managed and funded by the Ministry of Public Health. Accreditation development began in 2001, and the first operational survey has not yet started. The programme is focusing on all levels of care, with particular attention to government hospitals. Accreditation standards are still in the drafting stage.

About 40 local surveyors are engaged in a local training programme in 2002. The local surveyors are selected by the Ministry of Public Health hospital administrators. Criteria for selection are: senior position; interest in the programme; and having the required skills. The training programme for surveyors includes orientation about accreditation, survey process and quality assurance/quality management issues. The training programme ends with a written examination and oral interview.

**Questionnaire on accreditation activities in Kuwait**

<table>
<thead>
<tr>
<th>Name of your accreditation programme</th>
<th>Kuwait Health Care Accreditation Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme name in English</td>
<td></td>
</tr>
<tr>
<td>Address of the programme: Street, PO Box</td>
<td></td>
</tr>
<tr>
<td>City, Postcode</td>
<td>Kuwait</td>
</tr>
<tr>
<td>Country</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>965 4846 871</td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Website</td>
<td></td>
</tr>
<tr>
<td>Name of person to contact for this survey</td>
<td></td>
</tr>
<tr>
<td>Is there any law or directive requiring accreditation in your country? Yes/No:</td>
<td>Ministerial order 358/2001 Establishment of Accreditation and Quality Assurance Administration</td>
</tr>
<tr>
<td>Reference, year</td>
<td></td>
</tr>
<tr>
<td>How is the programme related to MOH/Government? managed by, (partially) funded by, formally Recognized by, totally independent of?</td>
<td>The programme is totally managed and funded by the Ministry of Public Health</td>
</tr>
<tr>
<td>What year did Accreditation development begins?</td>
<td>2001</td>
</tr>
<tr>
<td>What year was the first operational survey visit?</td>
<td>Not yet</td>
</tr>
<tr>
<td>Does the programme focus on primary or secondary or tertiary care? All of these</td>
<td>All; but more on Ministry of Public Health hospitals</td>
</tr>
<tr>
<td>Does it include public and private facilities?</td>
<td></td>
</tr>
<tr>
<td>Are the accreditation standards available to the public free of charge? Yes/No.</td>
<td>Still in drafting</td>
</tr>
<tr>
<td>If not, at what price can they be purchased? US$</td>
<td></td>
</tr>
<tr>
<td>Which foreign country most influenced the development of</td>
<td>Joint Commission International</td>
</tr>
<tr>
<td>standards in your country?</td>
<td>Accreditation (JCIA)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>How many full revisions of the standards have been published?</td>
<td>Basic requirements: 2 revisions/standards: draft</td>
</tr>
<tr>
<td>What year were current standards approved?</td>
<td>Basic requirements 2001</td>
</tr>
<tr>
<td>How many days does a site visit usually last?</td>
<td>Not yet</td>
</tr>
<tr>
<td>How many surveyors are usually in a team?</td>
<td>Not yet</td>
</tr>
<tr>
<td>Are full reports of surveys available to the public free of charge? Yes/No</td>
<td>Not yet</td>
</tr>
<tr>
<td>If not, at what price can they be purchased? US$</td>
<td></td>
</tr>
<tr>
<td>How many survey visits were done in 1999?</td>
<td>Not yet</td>
</tr>
<tr>
<td>How many trained surveyors were available to the programme at the end of 1999?</td>
<td>About 40 local surveyors are trained locally 2002</td>
</tr>
<tr>
<td>How many new surveyors were trained in 1999?</td>
<td></td>
</tr>
<tr>
<td>What was the total expenditure of the programme in 1999? US$</td>
<td>Survey visits not started yet.</td>
</tr>
<tr>
<td>What fee is charged to survey a 100-bed hospital? US$</td>
<td></td>
</tr>
<tr>
<td>What is the accreditation programme’s main source of income?</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>Please name any other national accreditation programmes in your country, with contact details</td>
<td>One private hospital is preparing for JCIA accreditation, emergency department is ISO certified.</td>
</tr>
<tr>
<td>Please add any other comments you would like to make about your programme or this survey</td>
<td>Quality assurance started in Ministry of Public Health in 1987, accreditation for training is managed by KIMS (Kuwait Institute of Medical Specialization)</td>
</tr>
</tbody>
</table>

3.5 Morocco

The population of Morocco (2000) is 28 787 000, with 45% in rural areas. The crude birth rate is 22%; crude death rate is 56%; annual population growth rate is 1.6%. Life expectancy at birth is 68 years; infant mortality is 36.6%; mortality under 5 years is 45.8%; maternal mortality is 22.8 per 10 000 live births.

The health care infrastructure is composed of 2267 health care centres; 3461 consulting rooms (private); 112 public hospitals with 25 000 beds; 192 private clinics with 3862 beds; and 23 clinics run by insurance organizations, with 1662 beds.

Indicators of supply are 1 health care centre per 12 700 population and 1 bed per 1000 population. The public sector (2000) has 5812 physicians (46% specialists); 39 pharmacists; 162 dentists and 26 124 nurse agents. The private sector has 6620 physicians (47% specialists), 5200 pharmacists and 2300 dentists. Health care worker to population ratios are as follows:

- 1 physician/2300 population
- 1 pharmacist/7700 population
- 1 nurse agent/1000 population.
Emerging problems are insufficiency and inequity in health financing, and productivity losses and growing economic burden (little recovery of hospital expenses; decrepitude of buildings; lack of equipment; weakness of health care quality).

The health sector strategy for 2000–2004 includes: decentralization policy; reform of public expenses; health system reform; PNAQ (national programme of quality assurance); and creation of a graduate training programme in hospital administration in the Institut National d’Administration Sanitaire (INAS).

The decentralization policy emphasizes the creation of an intermediate level between central and district levels; strengthening of hospital autonomy; decentralization of the planning function; and regional strategic planning of supply, including the participation of the private sector and civil society. Hospital strategic planning is also included.

During 2000–2003 a methodology will be elaborated for developing health care standards, with elaboration of standards for equipment, essential drugs and maternal care. There will also be continuous training and development of national QA experts to strengthen national the QA training. During 2003–2006 it is planned to implement an accreditation system within the scope of overall health system reform.

3.6 Oman

The population of Oman is 2.3 million, of which 74% are Omani and 26% are expatriates. The crude death rate is 3.5 per 1000 population; infant mortality rate is 16.2 per 1000 live births; and life expectancy is 72.4 years for males and 75.3 for females. Improved health indicators are having profound effects on the country’s current and future health needs in terms of the changing pattern of disease, from communicable to noncommunicable diseases; and the changing pattern of risk due to social and economic development.

Health sector development plans are concerned with the provision of comprehensive health services, promoting quality of health services and improving health status. The provision of quality health services has allowed for self-reliance and minimized the need for treatment abroad in cases requiring open heart surgery, renal transplantation, cornea transplantation and other major surgeries. A complete cancer unit is expected soon. Cancer cases represent 68% of cases treated abroad. The public sector accounts for 99% of all hospital beds.

The Ministry of Health, in previous plans as well as its current plan, has focused on developing and strengthening primary health care and using it as a portal for all other levels of health care. Quality assurance programmes in PHC facilities have been established. It is expected that these will expand to include all levels of health care. Decentralization of health care management of key hospitals is now in progress. This has resulted in redistribution of budget and workforce, with more authority for decision-makers and planners at hospital level.

The Ministry of Health has taken several steps to ensure that it reduces reliance on the expatriate workforce. Basic and post-basic training programmes have been increasing. The
Oman Specialized Nursing Institute was established in 2000. The Institute runs post-basic programmes of one-year duration and candidates are awarded diplomas. The programmes currently running are nephrology, midwifery, special care nursing in paediatrics and neonatal nursing. It is expected that more programmes will start in the next year, such as nursing administration and critical care nursing.

An increasing number of Omani doctors are graduating from Sultan Qaboos University. The Oman Medical Specialty Board has been set up to oversee specialty training for doctors. Paramedical programmes are also being run. Oman has 80% Omanis working in the field of laboratory science.

There are now a total of 49 hospitals, accounting for 4491 hospital beds, in the Ministry of Health, plus 3 hospitals in other government agencies, with 630 beds total, and 2 private hospitals with 50 beds. Basic quality assurance programmes are in place, and include continuing education programmes, the development and use of treatment protocols, auditing of different aspects of care, patient referral guidelines and mortality reviews.

A basic private sector licensing and regulation system exists under the control of the private health establishments. Doctors, nurses and paramedical staff are required to pass technical examinations in order to receive a license from the government. Private clinics and hospitals are also subject to licensing requirements that take into consideration infrastructure and equipment. A ministerial order was issued in 2001 to establish a national Quality Assurance Committee. A quality assurance adviser has been appointed and is in the process of developing a quality assurance department at the Ministry of Health.

While Oman’s health system performs well, there is still substantial scope for improvement. Although quality assurance initiatives are under way in most health facilities they are not well coordinated among the facilities and are not institutionalized within the Ministry of Health. There are no nationally recognized external hospital accreditation bodies. The Nursing and Midwifery Council is in the process of setting national standards for education and practice; similarly other professions are in the process of strengthening professional regulation systems. The strength of Oman is that there is significant political and management support for further improving health services.

3.7 Pakistan

The Government of Pakistan is focusing efforts on making primary health care facilities available to all citizens throughout the country. A nationwide network of health facilities staffed with trained health personnel is providing primary health care services to the clients. Health services in Pakistan give high priority to communicable diseases and nutritional deficiency disorders affecting children and women at reproductive age. There are 13,502 public health facilities, with 100,538 beds, available for provision of ambulatory and hospitalized care to the entire population.

The Federal Ministry of Health is mainly responsible for planning and formulation of health policies, containment of communicable diseases, coordination of health functions, drug
control, interprovincial coordination of health services, international relations in the health field and administration of postgraduate medical centres and colleges.

Provincial health departments are responsible for providing health services to the population through teaching hospitals and special institutions and the district health system. The provincial health departments are also responsible for management of federally designed priority health programmes such as the national programme for family planning and primary health care, expanded programme on immunization (EPI) and control of diarrhoeal diseases programme, AIDS control programme, malaria control programme and acute respiratory infection (ARI) control programme.

Pakistan has been undergoing rapid reforms in almost all its sectors during last 3 years. In August 2000, the government announced a plan to devolve financial and administrative authority to the grass roots level in order to bring government closer to the people and enable them to take more responsibility for their health and welfare.

The 400-bed Federal Government Servants Hospital was established in 1966. At present 31 dispensaries are also working under the administrative control of FGSH in different sectors of Islamabad and Rawalpindi. The centre provides medical care to federal government employees and their facilities and serves the general population. The following inpatient and outpatient wards are available in FGHS: medical, surgical, psychiatry, neurology, gynaecology, ophthalmology, ENT, paediatrics, nephrology, emergency, blood bank, X-ray and laboratory.

The Pakistan Institute of Medical Science (PIMS) started functioning in late 1985 with Islamabad hospital, Children’s Hospital, MCH centre, Quaid-e-Azam Post Graduate Medical College, College of Medical Technology, College of Nursing and School of Nursing. Islamabad Hospital is one of the major components of PIMS, with 573 beds and more than 22 specialties of medicine and surgery, intensive care, cardiac care, pathology, radiology, blood bank, angiography, cardiac nuclear laboratory, lithotripsy and physiotherapy units. The wards are equipped with the latest equipment and headed by consultants. More than 2000 employees work in the hospital.

The Children’s Hospital was established to provide tertiary care and act a model for management of childhood illness. Patients from northern areas and different parts of Pakistan are referred to this centre for advanced treatment. The centre trains postgraduate students in paediatrics for DCH, MD and FCPS courses.

The MCH centre, with a 125-bed hospital, was established with the help of the Japan International Cooperation Agency. This is closely connected with the technical cooperation project for Safe Motherhood in Pakistan. Patients requiring specialized treatment from all hospitals from Rawalpindi, Islamabad, Punjab and North-west Frontier Province are also referred to this centre.

Accreditation in the health care system in Pakistan means certification/registration of organizations involved in the delivery of health care, including drugs, equipment and supplies,
for the purpose of providing quality health care. An administrative body that ensures provision of high quality health care services and that fulfils the organization’s goals, mission and objectives usually does this task.

The Government of Pakistan has a vision to provide quality health care on an equitable basis. The Federal Ministry of Health has already laid down a system of accreditation in following areas:

- **Medical Education:** Pakistan Medical and Dental Council
- **Drug Manufacture and Quality Control:** in the Pakistan Drug Act of 1996, all manufacturers and importers of drugs are to be licensed and registered
- **Good Manufacturing Practices (GMP):** compliance to GMP is to be verified and tested before licensing of manufacturers and importers.

Different accreditation bodies have been proposed for implementation of the above-mentioned laws. For example, a Board of Accreditation has been proposed for the regulation of medical education and training in Pakistan. Similarly, a Medical Inspector may be appointed to grant certificates to all private hospitals clinics and clinical laboratories under the law which is being proposed for regulation of these institutions. A medical *mohtasib* (ombudsman) will also be appointed to look into any patient complaints.

The implementation process may face certain obstacles that the national coordinator must be well prepared in advance to resolve. Such obstacles include the following:

- Lack of trained personnel and other resources
- Poor governance and management
- Lack of clear follow up mechanism
- Absence of necessary legislation for implementation of standards
- Un-availability of practical and implementable standards in various areas.

### 3.8 Saudi Arabia

In November 2001 the Minister of Health formed an ad hoc committee to develop national standards for accreditation of health care facilities in Saudi Arabia. The committee includes representatives of nine health care providers in the country, and is chaired by the Director General of the Quality Assurance Department in the Ministry of Health.

Goals of the committee are to:

- Establish standards that responds to patient needs and expectations with available resources, for all sectors across the country
- Develop standards that take into consideration the concept of continuous quality improvement (CQI)
• Develop training programmes for health care employees in order to implement these standards

• Continue evaluation and assess implementation process of the standards.

Available sources include the Ministry of Health assessment format for hospitals (2001); Canadian Council on Health Care Services Accreditation (1992); JCAHO and JCIA standards for hospitals (2002); Saudi Aramco medical services organization standards (2002); and WHO standards for district Ministry of Health facilities.

The framework used will include the following steps:

1) Start with hospitals then polyclinics at a later stage.

2) Focus on development of structural standards with emphasis on issues which have greatest impact on patient and employee safety.

3) Decide upon content after review of different available resources.

4) Draft the structural standards for different services.

5) Revise the draft by experts in specific services.

6) Examine the standards in pilot studies.

7) Implement standards for the purpose of accreditation.

3.9 Syrian Arab Republic

In 1998 an office for quality assurance was established in the Ministry of Health of the Syrian Arab Republic to train people on QA/I implementation in Ministry activities. In 2000 the first meeting of central quality team convened to develop national quality standards of health care facilities/services in the Syrian Arab Republic. Goals of the central quality teams are as follows.

• Establish standards that responds to patient needs and expectations with available resources, for all health organizations.

• Develop, implement and update standards that take in consideration the CQI (TQM) concept.

• Develop training programmes for health care employees in order to implement these standards.

• Evaluate and assess the implementation process of the standards.
In each Ministry of Health directorate, health governorate and hospital, quality teams were established to set local quality standards for health services (health care and administrative procedures) after undertaking training courses in quality system implementation and certain necessary skills (QC tools, problem solving techniques and computer skills). They meet periodically to share information, knowledge and experiences and to conduct research on quality issues. In 2001 a special technical committee was formed to study and adapt accreditation standards after reviewing American standards.

3.10 Tunisia

Hospital accreditation has not yet been implemented in Tunisia. However, the Ministry of Health is working to develop the necessary prerequisites. Norms and standards concerning facilities, buildings and human resources (needs and qualifications) were adopted in 1993, and a national sanitary information system is being developed. Currently there are a number of public and private initiatives to set up mechanisms in order to ensure high quality in health care provision. One private clinic is obtaining ISO certification.

Average life expectancy in the country is 72.1 years (1999), 70.1 for men and 74.1 for women. Infant mortality (per 1000 live births) was 262 in 1999 (1386 in 1966); maternal mortality (per 100 000 births) was 69 in 1993 (134 in 1966); and 85.2% of deliveries were assisted by trained personnel in 1998.

Resources in Tunisia include 1.8 beds per 1000 population (170 health care units divided into 3 levels); 1 basic health care centre per 4000 population; 4200 doctors, 400 dentists and 28 000 paramedical staff. Geographical accessibility of the health care units is satisfactory.

Weaknesses in public health care include unequal distribution of resources; inefficient use of resources; weak internal organization of health care management; weak medical information system; and limited temporal accessibility (external consultations).

Private health care weaknesses are heavy concentration of private medical services in the large urban centres, with no regulation concerning the geographical distribution of health care units (except for dialysis centres), and low involvement in national sanitary plans.

In the semi-public health care sector, there are hospitals and units belonging to the Ministries of Defence and Interior, clinics for ambulatory care belonging to the national social security fund (CNSS) and medical centres belonging to national companies. This sector improves health care accessibility for some categories of the population and participates in the development of health care and in improving new technologies.

Almost all the population is covered by a scheme to cover health care expenditures. Total health care expenses have increased significantly much faster than the growth of the GDP. The weaknesses of the system are the multiplicity and heterogeneity of the various schemes, which leads to high health care consumption/waste; inequities between the insured (contributions vs benefits); and low public financing of the private beneficiaries.
Tunisia gains almost 500 new doctors every year. Qualifications and course of study must be adapted to produce general practitioners and/or family doctors, in relation to the needs of the population. Attention must also be given to balancing general practitioners versus specialists. Ongoing medical training is essentially through professional organizations with lack of efficient assessment mechanisms to assure coordination between various sectors. Administrative and regulatory weaknesses include the following:

- Insufficient norms and standards in the public sector.
- Lack of price regulation in the private sector.
- Lack of a national strategy of continuous quality insurance involving all parties.
- Centralizing the public management procedures (investments and human resources).

In conclusion, the strengths of the Tunisian health system must be consolidated and reinforced to cope with new challenges: epidemiological transition; reaching a consensus for the development of the health system; systematic assessment of the development of the health sector; and ensuring a balance between equity, efficiency and quality.

4. PROPOSED MODEL OF ACCREDITATION

In 1951, the American College of Surgeons, American College of Physicians, American Hospital Association, and the American Medical Association cooperated to form the Joint Commission on Accreditation of Hospitals to address the need to improve the quality of care in the United States of America. Today it is the primary instrument used by the United States Health Care Financing Administration to approve the transfer of medicine funds to hospitals. Only hospitals that have passed an accreditation process can receive payments. Countries in other WHO regions have also employed this method, such as Egypt and Lebanon (EMR); Brazil and Argentina (AMR); Thailand, Taiwan and Indonesia (SEAR); England, France and Spain (EUR); South Africa (AFR); and Korea (WPR).

Accreditation has been defined as a “system of external peer review for determining compliance with a set of standards.” It is a procedure that evaluates the institutional resources periodically and confidentially, seeking to ensure the quality of care on the basis of previously accepted standards. Standards may be minimal, defining the bottom level or base, or more detailed and demanding, defining various levels of achievement. A health care establishment is said to be “accredited” when the disposition and organization of its resources and activities make up a process which results in medical care of satisfactory quality. Accreditation implies confidence in a hospital by the population. In almost all cases this can be achieved without major investments in infrastructure.

There are three main purposes of accreditation:

1. Quality improvement: using the accreditation process to bring about changes in practice that will improve the quality of care for patients;
2. Informing decision-making: providing data on the quality of health care that various stakeholders, policymakers, managers, clinicians and the public, can use to guide their decisions;

3. Accountability and regulation: making health care organizations accountable to statutory or other agencies, such as professional bodies, government, patient groups and society at large, and regulating their behaviour to protect the interests of patients and other stakeholders.

Standards are statements of expectation that define the structures, processes, and results that must be firmly established in an organization so that it may provide quality care. For example, *standard of structure* refers to equipment, physical area, support services, personnel; *standard of process* includes admission, nursing procedures, medical procedures, operational manuals, norms, routines, flows; and *standard of outcomes* covers mortality, morbidity, readmissions, complications, infections and client satisfaction (accessibility, information, personnel and facilities.). All these standards require evidence of performance (or qualitative indicators) that are simple, inexpensive and easy to observe by the surveyors.

In the Eastern Mediterranean Region there is often great diversity of hospitals within the same country. Although there may be prominent public and private medical centres, comparable to the most advanced in any other Region, many of these hospitals would not pass an evaluation review for a minimum level of quality in some services. Currently, as well, many hospitals have a great variation in quality among their services, independently of their size.

Major reasons for implementing accreditation are as follows:

- It stimulates the improvement of care delivered to patients
- It strengthens community confidence in its hospital
- It reduces unnecessary costs
- It increases efficiency
- It provides credentials for education, internships, and residencies
- It can protect against lawsuits
- It facilitates acceptance by and funds from third-party payers

The following concepts are important in accreditation methodology:

- Accreditation is not the goal; the goal is to improve the quality of each hospital service
- The emphasis is on the total hospital system (and its processes)
- Educational programmes are essential
- Standards for accreditation will evolve as the countries’ hospital services progress
- The final verdict of accreditation is based on a consensus among the surveyors
- The standards should reflect the average status of hospitals in a country.
In the draft manual of hospital accreditation (Annex 4), standards are organized by increasing and related degrees of quality performance (or complexity) in such a way that to attain a superior level of quality for a specified hospital service, the standards for inferior levels must necessarily be satisfied. The standards seek to evaluate, within a single service, aspects of structure, processes and results, through qualitative and dynamic evidence of performance or indicators that reflect the quality of services provided. To establish a given level for each item, the evaluation should begin at inferior levels until reaching the level where the requirements are not completely satisfied.

Qualitative indicators, or evidence of performance, are described for each standard and designed to ascertain the degree to which measures prescribed by standards are carried out and their effect on patient care. The data collection process for observing qualitative indicators is designed to be as simple as possible. The results should offer information useful to those in decision-making or managerial positions to help them make necessary changes. For countries that do not have sufficient valid or reliable information for statistical analysis, or where adequate numerical data have not been collected, the indicator for each standard will be determined by qualitative observation using surveyor consensus. In the future, and to the extent that data are collected and analysed, one will be able to develop statistical interpretations to establish quantitative observation.

The evidence of performance of standards is not assessed through a checklist. Hospitals are unique entities, each with its own tradition, culture, and background. The surveyors will establish a tailor-made model of assessment for each hospital, defining how, when and what will be assessed first, and this flexibility cannot exist in a rigid checklist. Accreditation is still a very subjective type of assessment. For this reason, highly competent surveyors must be selected.

Currently, qualitative indicators point to sources where surveyors can seek evidence, or where a hospital can show surveyors that it is, or is not, complying with the stated standard(s). These sources might be documents, interviews, medical reports, patient records, etc.

The draft accreditation manual covers all services of a general hospital for treatment of acute cases. It is intended to serve not as a national requirement, but rather as an illustrative guide for national multi-institutional commissions when formulating their own evaluation tools. Increasingly complex standards, or those that evolve continually, have been established for each hospital service, from an initial “threshold” to more sophisticated levels. These standards represent the expected level of desired care, practice, or methods defined by national experts and/or professional associations. In each situation, the initial standard is the required minimum level of quality. No country’s hospital hopes to find itself below this level, within a specified period of time, for example. As these initial standards are met, subsequent steps are addressed to reach successive standards. Thus, when the standard for the basic level is met, the next step is to reach the second and then the third levels, progressively.

As a hospital is not comprised of independent or isolated services, it is necessary that all its services, from the laundry to the operating room, or to staffing of the intensive care unit, for example, reach at least the basic level standard in order for the hospital to be accredited
and receive the resulting public recognition for good quality medical care that accreditation brings. An isolated service is not “accredited.” Even if a hospital unit is fully equipped and of exceptional quality in some units or services, with sophistication levels at 3 or 4, the institution will continue to be accredited at the first level if other services do not exceed the first level.

This methodology attempts to reinforce the fact that hospital structures and processes are so integrated that poor functioning in one component interferes throughout and in the final result. Thus, a hospital “is” or “is not” accredited as a whole, indivisible unit. Distinct levels of accreditation are not established for secondary and tertiary care hospitals. It is commonly observed that hospitals perform complicated clinical procedures, however, the surgical centre, for example, must interrupt its activities for lack of linens.

The methodology proposes that each service or hospital department standard reflects increasing performance of care. This promotes an environment of continuous improvement, because there will always be standards of higher complexity to pursue. Before, during and after an evaluation for accreditation, administrators must gradually develop items to identify and distinguish discrepancies between practices and acceptable standards of quality, finding ways to correct or reduce deficiencies.

The draft manual of hospital accreditation recommends the use of levels of standards of accreditation of increasingly complexity. The accreditation process may observe some specific principles. For example, Level 1 should characterize the clients’ “safety” (mainly structure component); Level 2 is more oriented at “safety” and “organization” of the hospital (mainly process component); and Level 3 is for “safety”, “organization” and “management and quality” (mainly outcome component).

**Level 1:** The demands of this level observe basic quality of care compatible with institutional resources. The services, units or sectors have responsible certified personnel, observe formal safety requirements and have appropriate infrastructure to implement activities within the corresponding rules and regulations.

At this level, surveyors should verify the following evidence of performance:

- Responsible certified personnel
- Functional personnel according to service needs
- Structural and operational conditions according to safety requirements for hospitalized and outpatient clients.

**Level 2:** At this level, in addition to Level 1 standards, there should be evidence of organizational planning of care in relation to documentation, training, control, and decisions making based on information and the internal audit. Services, units or sectors have documented process and procedure manuals that are up-to-date and available, as well as clinical protocols and basic statistics; continuous education programmes are offered for the improvement of processes, sentinel events and evidence of integration with other hospital services.
At this level, the surveyors should verify the following evidence of performance:

- Up-to-date and available process and procedure manuals
- Qualified professionals
- Groups for process improvement
- System of critical case assessment to control eventual problems or risks, procedure improvement
- Patient orientation
- Continuity of care and case follow up.

**Level 3:** At this level, in addition to Level 2 standards, there should be evidence of institutional policies for continued improvement in terms of structures, processes, procedures, technology upgrades and outcomes or impacts. The services, units, or sectors have measurement systems for client satisfaction; integration with the institutional quality and productivity programme; evidence of improvement cycles; data information systems and indicators that allow service evaluation; and community impact.

At this level, the surveyors should verify the following evidence of performance:

- Planning and continued improvement systems relating to structure, processes and results; new technologies; refresher courses in clinical care actions and procedures
- Cycles of improvement with systemic impact
- Information systems based on indicators that allow analysis and comparisons
- Permanent system of satisfaction of inpatients and outpatients.

5. MAJOR CHALLENGES IN IMPLEMENTING HOSPITAL ACCREDITATION

**Dr H. Novaes, WHO Consultant**

- Legal considerations. Executive orders, laws or regulations of the Ministry of Health are important and useful, but should not be the paramount factor. In some cases, a change in Health Ministers can hinder implementation of the policy, even if it has just been announced by decree or through regulations, if the new Minister does not consider it a priority to encourage the national process of accreditation for political reasons. Thus, the initiative is delayed until another Minister presses the issue.

- Lack of an inter-institutional and independent National Commission on Hospital Accreditation. Such a commission is always the goal to be reached, although it is not easy to achieve consensus among the different actors in the public and private health sectors to work together with a common goal. Another threat is the appearance of multiple accreditation entities, competing among each other, and setting different standards, priorities, and fees. This can affect the entire accreditation process negatively, leading to the possibility that if a hospital is not accredited by one entity, it may be accredited by another, under different standards. It is essential to have uniformity; therefore there must be a National Commission that applies uniform accreditation standards to be followed by state or provincial entities.
• Lack of participation by the insurance sector. The role of public or private social security and private health insurance is vital for implementation, since the inclusion of accredited hospitals in their list of providers characterizes the importance of hospital accreditation as an instrument to ensure quality of care for the clients of these institutions. Private insurance companies are beginning to analyse this situation; however, many countries unfortunately do not yet have a process to tie national accreditation to contracts for hospital services.

• The non-application of minimum standards, as opposed to optimum standards. It is necessary to implement basic standards during the beginning of hospital accreditation development. This seems to be the most rational approach, since no country would be likely to have adequate and sufficient human and financial resources to correct deficiencies throughout all of its hospitals, whether structural or process-related, using optimum standards. Since the methodology anticipates that each hospital service will have increasingly complex standards, the highest level of standards would be considered ideal or optimal (Level 3). Generally, professional associations, such as medical or nursing associations, always strive to establish optimum standards, although when starting to implement the accreditation process, they convince themselves that it is not possible to begin with very sophisticated levels. Consequently, very few hospitals, in the short term, manage to be in a position to implement optimum standards.

• Ensuring standards for all hospital services instead of for a few units. Approval of particular units or isolated programmes has been supported by some groups, by those in charge of the programme for prevention and control of hospital infections, or isolated accreditation of hospital laboratories. A hospital may have a good programme in place to control infections or a good clinical laboratory, but this does not always ensure that other services are in a position to be accredited, even using minimum standards.

• Risk of assigning points, or giving a precise value or numerical score to findings. This approach results in problems because in some cases, the sum total of points may mask areas with deficiencies. Instead of giving a score, the surveyors, by consensus, should agree at the end of the accreditation visit whether the hospital is or is not accredited, or if some time is required to correct deficiencies (partial accreditation).

• Confusing licensing with accreditation. Some countries, have not yet instituted a national hospital licensing system, or a system for initial health permits for construction or renovation, which are generally issued by municipal authorities and which almost always deal only with observable structural features (licensing). When a country tries to use accreditation as a tool for licensing, the degree of complexity created renders accreditation impractical.

• Ensuring sustainability of a national accreditation programme. Although accreditation may be voluntary on the part of hospitals, these institutions must have some incentive for accepting the accreditation process. In the United States, for example, the vast majority of hospitals survive as a result of patients covered by Medicare, or social security for the elderly. For a hospital to be contracted under Medicare, it must have
prior accreditation from the National Accreditation Commission. Similar incentives for sustainability of this process will be required in countries of the Eastern Mediterranean Region.

- Misperception of the role of surveyors. The accreditation process must always be viewed as an auxiliary and permanent educational activity for hospital staff, never as a bureaucratic inspection or critical audit in search of victims. The basic role of surveyors should always be seen as that of specialized consultants helping the hospital to overcome its managerial or technical difficulties. Assessment teams generally include a physician recognized for his/her skills, a nurse with far-reaching experience in hospitals, and an administrator with a solid background in hospitals. In many countries, most of the hospital administrators are physicians, but in the surveyor team they are only “administrators,” leaving the clinical side to be observed by the physician on the team.

6. GROUP WORK

6.1 Overview

On the second day the participants were divided into three groups to review the draft manual. Heterogeneity regarding countries and professionalism was considered in selection and distribution of groups. Each group was responsible for reviewing 14 standards on hospital accreditation. The objective was to discuss a set of standards with emphasis on the technical merit, consistent with current evidence, and its validity and reliability for the Region. Group inputs on standards were included in the draft manual.

New tasks were assigned for groups on the third day. Group 1 was requested to review the national and local steps of accreditation process. The objective was to determine how to promote the implementation, at the national level, of a process of continuous improvement of the quality of care through wider dissemination of the manual on accreditation and enhance appreciation of the usefulness of accreditation standards. Group 2 reviewed the local steps to determine how to promote the implementation at the local level (health facility level). Group 3 was responsible of reviewing the introduction of the draft manual. The objective was to ensure the feasibility of the methodological consideration at the national level and the clarity of instructions and procedures. A recommendations committee was also selected to set recommendations for both the country representatives and WHO/EMRO.

Group presentations then took place and group input on the national and local steps for launching accreditation programme was included. After the presentations another round of discussion took place regarding the need to build up a mass of expertise in surveying, provision of incentives (national and local) to motivate adoption of the programme and the value of developing a survey checklist to reduce subjectivity. The group then agreed that ensuring unanimous clarity of the standards would reduce subjectivity and that checklist could be developed at a later stage. The three groups met again to review and discuss the recommendations proposed by the recommendation committee and their input was included. They also discussed how to promote the implementation of accreditation programme and
develop general cooperation agreements between countries and participating organizations, to support the initiatives being undertaken by the participants in their respective countries.

6.2 Preparation for launching hospital accreditation

Currently, there are great discrepancies in quality among different services of the same hospital, independent of the number of beds. Faced with this scenario, the Regional Office is developing, with the collaboration of countries, a hospital accreditation model that is appropriate for the Region and that is flexible enough to allow for adaptations of major differences. The model accreditation guidelines for the Region will cover all services of a general hospital for treatment of acute cases. They are intended to serve as an illustrative guide for national multi-institutional bodies when formulating their own evaluation tools.

Many government, semi-private and private health institutions seek a recognized accreditation system in order to cope with the newly emerging competitive environment of health care service delivery. Hospital accreditation processes have recently begun to be implemented in some countries in the Region. Institutionalizing improved quality of care through accreditation requires more than a technical approach; more than the application of tools and methods. Failure to change the behaviour of people and organizational attitudes is the commonest cause of ineffective quality initiatives. Sustained improvements often require a change in attitude and acquisition of a sense of ownership with regard to the quality of services provided by an organization. Many supporting factors are required to integrate accreditation into the structure and function of an organization. The challenges in setting and measuring against standards are mostly technical; the challenges in making appropriate changes are social and managerial. Sustainable quality needs a supportive environment of leadership, clarity of purpose and organization, in other words, a strong accreditation programme. Accreditation can be the single most important approach for improving the quality of health care structures.

Hospital accreditation is a method of ongoing consensus, rationalization and hospital organization. The first instrument for the explicit and objective technical evaluation of quality was the accreditation manual. The creation of the National Accreditation Body was of great importance. It should be apolitical, multi-representational, and should undertake its work energetically, prudently and periodically. This entity will be responsible for the administration and policy-making of the accreditation system at the country level. It will be responsible for the setting of national standards for accreditation, adopting WHO guidelines for accreditation, identifying and training the surveyors, conducting and monitoring the site surveys and making the decisions related to the awarding of accreditation and maintaining it. It is essential to have uniformity; therefore, this body should apply uniform accreditation standards to be followed by state or provincial entities.

In spite of recommendations that the national accreditation body be multi-institutional, and include the most prominent and active players in the civic, public and private sectors of the national health sector, the presence of the Ministry of Health is essential because of its authority and its capability of transferring resources within the process of national hospital accreditation. The mandate of such a regional entity would be to ensure that national
accreditation systems are competent to: monitor and evaluate adherence to national health system policy and responsiveness to current and future challenges; monitor and evaluate quality performance of health organizations/facilities on various levels; cover managerial and clinical aspects; enhance organizations’ learning environment and quality improvement culture; and establish a national framework to take full responsibility for the accreditation initiative.

This national ownership is crucial, both to lay the foundation and to maintain, from the beginning, a high degree of integrity as well as accountability of the national accreditation system.

6.3 Implementing hospital accreditation in countries of the Region

The following steps are suggested to be followed by countries of the Eastern Mediterranean Region.

1. Orientation of national authorities within the Ministry of Health and other stockholders on concept, methodology, benefits and expected outcomes of Accreditation by EMRO and members of consultative meeting.

2. Launching of the accreditation process by establishing an ad hoc national accreditation committee (NAC) by the Ministry of Health.

3. Presentation of the accreditation manual to the national accreditation committee.

4. Contact with the country leadership by the national accreditation committee.

5. Review and adaptation of the WHO manual by the national accreditation committee.

6. First national seminar on hospital accreditation, “Validation of standards and evidence of performance (qualitative indicators)”.

7. Identification of available resources and existing ongoing activities on Accreditation and Quality Improvement throughout the country by the ad hoc National Committee.

8. Selection of public and private, large and small hospitals as pilots.

9. National seminar on hospital accreditation, “Presentation of the accreditation process in pilot hospitals”.

10. Establishment of a permanent multi-institutional national commission/council representing health care providers, independent or semi government organization, universities, insurance companies and/or community representatives.

11. Reformulation of some standards and indicators based on the pilot study.
12. Initial formal surveyor training.

6.4 Hospital accreditation at the local level

At local hospital level the expert group recommended the following steps to implement the accreditation process:

- Contact with hospital authorities
- Configuration of the hospital accreditation committee
- Training staff on concepts of accreditation; presentation of the manual to governing bodies and hospital committees
- Communication of these standards to those who must use them;
- Self-evaluation, based on proposed standards for services
- Design of situational profile.
- Implementation of a plan of action to improve the standards that did not reach the minimum level.
- Problem solving and process improvement. Solutions to problems can be sought through mutual help and cooperation.
- Training and monitoring the plan of action
- Report to the hospital authorities.

6.5 Plan of action for hospital accreditation at the country level

<table>
<thead>
<tr>
<th>Task</th>
<th>Week</th>
<th>Purpose</th>
<th>Activities</th>
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<tbody>
<tr>
<td>Steps 1, 2 and 3</td>
<td>To be established</td>
<td>i. Presentation of the accreditation manual to national and regional authorities representing the health sectors (public and private)</td>
<td>Meeting with professionals representing national/provincial/local</td>
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<td>ii. Conceptual and methodological consolidation of a national programme with the participation of governorate/province surveyors</td>
<td>Meeting with groups who applied the accreditation model (if applicable)</td>
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<td>iii. Constitution of the ad hoc national accreditation commission</td>
<td>Visits country health leadership (national/regional/local)</td>
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<td>Step 4</td>
<td>Ad hoc accreditation commission for the revision of accreditation manual</td>
<td>Establishment of the working group in charge of the preparation of the preliminary version of the accreditation manual, and other instruments</td>
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<tr>
<td>Step 5 and 6</td>
<td>Working group meetings at the national/provincial level; preparation for national seminar</td>
<td>Revision of the first version of the accreditation manuals; Pilot application in the field (states/provinces): large, small, public and private hospitals</td>
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<td>Step 7</td>
<td>National seminar</td>
<td>Presentation of the results of the accreditation assessment; national meeting</td>
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<td>Step 8</td>
<td>Consolidation of the principles of the accreditation manual</td>
<td>Immediately after national consultations, permanent project personnel should prepare the formatting, editing, and publication of the document, including all revisions</td>
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<td>Step 9</td>
<td>Revision of legislation and proposals for the establishment of an oversight programme at the national level</td>
<td>Analysis of current legislation for the implementation of the national accreditation programme, offering alternatives to the Ministry/Department of Health</td>
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<td>Step 10</td>
<td>Standards for the establishment of governorate/provincial commissions of hospital accreditation (if applicable)</td>
<td>Preparation of the criteria that will be set for the establishment of provincial commissions for hospital accreditation</td>
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<td>Step 11</td>
<td>Elaboration of the curricular model for the preparation of surveyors (nurse, physician, and hospital administrator)</td>
<td>Preparation of course modules to train surveyors; characterizing accreditation procedures as educational instruments to improve hospital management; workshop with and/or international consultants</td>
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<tr>
<td>Step 12</td>
<td>Proposal for the financial sustainability of the national programmes</td>
<td>Analysis of economic alternatives for the feasibility of the national hospital accreditation programmes</td>
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<tr>
<td>Step 13 and 14</td>
<td>i. International workshop to present the countries hospital accreditation programme; ii. Presentation to the Minister of Health, or equivalent, on the status of country proposals on hospital accreditation</td>
<td>International seminar, 2 or 3 days, in the capital of the country or alternative location agreed upon</td>
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6.6 Surveyors

The role of surveyors is crucial to the credibility and sustainability of accreditation. The expert group recommended the following criteria for selection of the surveyors:

- Experts in the field (medicine, administration, nursing)
• Skills for interpersonal relationships
• Management experience
• Knowledge of standards and methodology
• Knowledge about quality assessment methods.

Surveyors should be trained in the following areas:

• Visits and teamwork, not inspection
• Handling of a daily agenda-time management
• Knowledge of standards and indicators
• Communication skills
• Handling difficult situations.
• Skills to describe findings in detail and precise summaries
• Ethical issues such as confidentiality and others.

7. RECOMMENDATIONS

To Member States

1. Conduct an intensive programme awareness-raising campaign, including capacity building, dissemination of concepts and seeking commitment, to promote accreditation of health care delivery services.

2. Seriously consider the implementation of the WHO/EMRO suggested steps for launching the accreditation programme. A clear national vision, mission, scope, goals and objectives for the programme should be the starting point at the national level.

3. Exert all possible effort to include accreditation in strategic national health plans.

4. Issue regulations necessary to ensure credibility of the national accreditation programme.

5. Determine the requirements for financing and sustainability of the national accreditation programme and identify necessary financial resources and potential funding sources.

6. Develop national expertise in quality improvement and accreditation.

7. Share progress and constraints with EMRO and seek relevant support where needed.

To WHO/EMRO

8. Continue supporting the development of accreditation programmes in countries of the Region through the joint programme review mission planning exercise.

9. Prepare an orientation paper on hospital accreditation including its implementation, for discussion at the 2003 Regional Consultative Committee meeting and Fiftieth Session of the Regional Committee for the Eastern Mediterranean.
10. Support countries in developing action plans to launch accreditation programmes.

11. Develop a monitoring tool to follow up and assess progress of Member States in implementing their accreditation programmes.

12. In collaboration with Member States, involve the identified responsible national officials for the national health care accreditation programme.

13. Enhance partnership with regional (such as the GCC) and international organizations to expedite implementing accreditation programmes in the Region.

14. Organize an expert group meeting in November 2003 to address: surveyor training package; awareness package; and updating of the manual.

15. Facilitate exchange of information on country initiatives and progress in accreditation programmes among countries of the Region.
Annex 1

AGENDA

1. Inauguration
2. Election of officers
3. Adoption of programme
4. Briefing on previous WHO accreditation meetings
5. Presentation on the concept of hospital accreditation and its application
6. Country experience in accreditation models
7. Organizational components of the accreditation model
8. Setting standards for hospital accreditation
9. Introduction of a proposed model of accreditation for countries of the Eastern Mediterranean Region
10. Establishment of national bodies on hospital accreditation
11. The process of hospital accreditation
12. Promotion of hospital accreditation and training surveyors
13. Recommendations and follow up actions for the promotion of hospital accreditation in Member States
14. Policy directions review of WHO/EMRO for accreditation
Annex 2

PROGRAMME

Monday, 23 September 2002

08:30–09:00  Registration
09:00–10:15  Opening session
  Message of Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean
  Introduction of participants and resource persons
  • Election of officers
  • Adoption of agenda and programme
  • Objectives, expected outcome, and methodology of the meeting/Dr Ahmed Abdellatif, WHO/EMRO
  • Briefing on WHO Hospital accreditation policy/Dr F. Siem Tjam, WHO/HQ
  • Briefing on previous WHO accreditation meetings/Dr F. Al-Darazi, WHO/EMRO
10:15–14:30  Plenary session 1
  Discussion
  Country experience in accreditation models*
14:30–17:30  Presentations and general discussion on the different models on accreditation.
  Presentation on the concept of hospital accreditation and its application (Dr Humberto M. Novaes, WHO Consultant)

Tuesday, 24 September 2002

08:30–09:30  Rapporteur summary: EMR status report on accreditation initiatives
09:30–10:30  Introduction of a proposed model of accreditation for EMR Member States/Dr Humberto M. Novaes, WHO Consultant
  General discussion
10:30–17:30  Group work: session 1
  Studying the organizational components of the accreditation model
  Setting standards for hospital accreditation

Wednesday, 25 September 2002

08:30–10:30  Group presentation: session 1
10:30–11:00  Implementing hospital accreditation/Dr Ahmed Abdellatif, WHO/EMRO
11:00–17:30  Group work: session 2
  Establishment of national bodies on hospital accreditation
  The process of hospital accreditation
  Training and promotion of hospital accreditation
Thursday, 26 September 2002

08:30–10:00  Group presentations: session 2
09:30–10:30  Major challenges faced in implementing hospital accreditation
10:30–16:00  Group work: session 3
          Feasibility, suggestions, recommendations and follow up actions for the
          promotion of hospital accreditation in the Region
16:00–17:00  Recommendations and conclusions
          Presentation of summary recommendations by the Rapporteur
          Approval of the proposed model of accreditation for countries of the
          Region
          Presentation of proposals by countries and action steps by countries
          General discussion
17:00 –17:30  Closing session
Annex 3

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Mrs Deya El Assra, Administrative Assistant, WHO/EMRO
Mrs Nahed Zeid, Secretary, WHO/EMRO
Annex 4

DRAFT MANUAL ON HOSPITAL ACCREDITATION

This manual was adapted by INTECH, Inc.* and especially designed for the WHO/EMRO Intercountry workshop and is based on the document “Standards and Indicators for Hospital Accreditation in Latin America,” by Drs Humberto M. Novaes and Jose M. Paganini, published by PAHO/WHO, with support of Dr. Hugo Arce and collaboration from ITAES. Reproduced with authorization.

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BACKGROUND

At the beginning of this new century, countries of the WHO Eastern Mediterranean Region present a great wealth of social and political experiences which, although facing a context of economic and financial challenges, show unmistakable signs of a society engaged in a process of transformation and maturation. In several countries the health sector has been developed over the years with planning and stable political conceptions to orient the investment and development of the health sector. This took place, however, without a continuous quality improvement program or an analysis of outcomes related to the quality of services provided to improve the quality of health care. Consequently, the policies applied had only partial goals and results that did not reorganize or reorder the entire sector, but only some of its components.

The need to improve quality has been an issue in health care for many years. A step forward, since 2000, compared to other periods, are the improved systems and methods that now exist to help health care organizations improve quality. In addition, it has become a social imperative that this is carried out because almost all users, providers, and purchasers are aware that health care services and systems can be continuously improved. Consequently this social imperative has stimulated many countries to embark on health care reform initiatives.

Factors that contribute to this imperative are: increased patient awareness of their rights as consumers of health care, increased attention to quality in all industries because of the recognition that quality is the key to long-term success; and a need to control health-care costs.

Health care reform can be considered successful only if the quality of care improves as a result of the changes introduced by reform. In turn, the spontaneous growth of some of the sub-sectors brought about a clear-cut separation between private activity, the public sector, and/or social security systems, forming provider systems with their own problems which, though independent in their origins, nevertheless exacerbated the effects of the financial and economic crisis currently afflicting the countries potential.

The organization and morphology of provider systems show the existence of compartments occupied by the professional sub-sectors (physicians, dentists, nurses, etc.), the health care establishments, and the drug market--each organized in accordance with the interests common to their particular activities and subjected to an unreasonable struggle, whose conceptual framework is impacted by the generalized limitation of resources.

Many of the current systems neglected an evaluation of the quality of individual and systematic institutional care, giving rise to an unnecessary increase in costs. Inversely, a trend emerged in the social security systems to lower expenditures regardless of real coverage needs. There are few health care providers who can ignore the demands to change their institutions and health care networks. Fortunately, health care professionals, by the very nature of their work and training, generally want to improve their patients’ outcomes and satisfaction. The challenge for health care leaders is to identify and successfully implement systems to harness and promote the desire of professionals to have to improve services and at the same time, meet the demands of consumers and other payers for more information about the quality of health care. The result of this equation has been an increase in the overall insufficiency of the system, reflected in increased medical care costs and a reduction in their quality.

Accordingly, the basic need arises to effect substantial and sufficient changes to deal with the deterioration of the quality of the health systems. Analysis of the factors responsible for deterioration of the efficiency of the health sector demonstrates that the deficit in planning leads to the existence of hospitals that frequently lack the minimum conditions for qualification, do not respond to the real needs of the population, and provide services that do not satisfy minimum quality standards.
Philosophically, and from a theoretical standpoint, it is impossible to deny the need to implement standards to improve the quality of medical care. However, the difficulties the various countries are undergoing frequently lead them to postpone such actions on the grounds that they would be neither feasible nor practical. This fallacy should be corrected by demonstrating that an effective means of remedying the deficit described is acting on the quality of care provided by optimizing the cost-benefit ratio.

Governments, accrediting agencies, insurers, and other parties interested in quality assurance have variously tried to design valid and reliable performance measures to objectively assess clinical competence. Among these are standards of practice are generic screens for reviewing records, a system for reporting adverse occurrences, practice guidelines and critical paths, and indicators of performance. In light of this reality, the utilization of suitable methods, such as hospital accreditation, for reorganization is a valid approach that acts as a guideline, maintaining its effect even in the event of possible modification of the coverage and financing system.

In the Eastern Mediterranean Region, awareness has grown of the special significance of the current stage of development of societies and of the projections of this situation for the coming years. We are undoubtedly witnessing a period of rapid change, affecting all aspects of our lives, and that have deep repercussions on the health situation and on the resources available for coping with it. It is imperative to understand this process and the consequent adjustments in the health sector and in society itself, if the goal set by governments to achieve health for all, with equity, effectiveness, efficiency, and participation, is to be attained.

The need exists to establish priorities for the development of health service infrastructures and for special attention to priority problems and groups in accordance with the primary care strategy. In response, in different countries, proposals have been drawn up to transform national health systems through the development of their district health systems and as an operational tactic to accelerate the application of the strategy of care and its essential components.

The development of a new model of health care should not be limited simply to a division of labor within a decentralized scheme of government. Rather, it should be a process of fundamental change in the technical procedures of service delivery, in the use of available technologies, in the integration of relevant knowledge, in the ways resources are used, and in the efforts to ensure social participation. A series of methodologies and basic principles based on these elements can be set to facilitate the development of new models of health care.

Based on these concepts, EMRO/WHO began to cooperate with Member States on the incorporation of hospitals in the health services network or district health services, to assure quality and efficient health care services. In this way, the Guidelines for Hospital Accreditation achieve the double role of presenting a flexible scheme to facilitate the incorporation of hospitals into the network of services, as well as to provide guidelines for quality development of services.

Analyses of the factors for health sector efficiency deterioration demonstrate that lack of planning leads to the existence of institutions that frequently lack the minimum conditions for licensing, and provide services that do not satisfy quality standards.
INSTRUMENTS THAT REGULATE THE QUALITY OF CARE

For the reasons stated above, we propose to act on the provider model, with instruments to regulate and guarantee the quality of care, expecting that this will contribute to improve the overall efficiency of the system and provide a consequent benefit for the population and participating sectors. For this purpose we will first of all focus upon the terminology for evaluating public and private hospitals. These procedures are as follows:

Licensing: This procedure is carried out by legal health authorities, or other entities in charge for this purpose. This is usually done only once, prior to the beginning of operations, and defines the local structural requirement.

Accreditation: Is a formal process by which an authorized health body assesses and recognizes that a health care organization meets predetermined standards designated to improve quality of care.

Categorization: This procedure refers to the classification of outpatient and hospitalization services according to criteria adopted (complexity, care risks, and the like) that allows the definition of levels, concentration of activities, classification of benefits. These must be feasible in relation to, and the kind, of hospital under study, and conform in the future within a local health services network (district health system).

Self-assessment programs (peer review): A process where by the performance of an organization, individuals or groups are evaluated by members of similar qualification internally.

There are, however, other kinds of self-evaluation, that are commonly defined with regard to explicit and acceptable performance criteria, and that are compared with the care provided. Various techniques may be applied in terms of self-evaluation, such as when the appropriateness of hospitalization is analyzed before patient admission into the health institution, when the kind of medical or nursing care is considered upon admission of the patient into the hospital, or after discharge, when the indications for follow-up in the short or long term are evaluated. Other examples of evaluation include referral and counter-referral within the network of services using tracer indicators, clinical sequelae, and the satisfaction of the patient and of the family members with the care received.

The working tools utilized are epidemiological, sociological, administrative, and clinical, adopted to coordinate the activities, such as hospital infection control, blood transfusion control, accessibility, use of drugs, pathological anatomy, medical records, etc. These activities represent what is being promoted as “Hospital Epidemiology.”

STRATEGY

Total or gradual implementation of the instruments mentioned should lead to the development of a regional or local strategy.

Licensing would consequently be the initial step for setting up a hospital. Accreditation will lead to gradual increase in the level of institutional quality of care provided. Self-assessment methods are specific intra-institutional procedures. Implementation of the referral and counter-referral instruments should lead to organization based on regional or local realities.
GENERAL CONSIDERATIONS

Methodological considerations

The preparation of this manual for the quality of healthcare constitutes an instrument to guide the evaluation of services or hospitals, with previously defined objectives.

To prepare the standards, the following criteria were taken into considerations:

1. The consideration of cost/benefit ratio during the evaluation procedures and excessively detailed procedure, which can be too much expensive in relation to the investment required in qualified personnel to carry out every evaluation.

2. In the detection of evidence of performance in a hospital, the objective should be focusing on the verification of the most representative data of existing conditions. The analysis of this data makes it possible to arrive easily at effective conclusions.

3. Simplification of the procedure requires outcome indicators (final results) that are essentially qualitative, and whose verification does not require prolonged accounts of events, but the observation of certain data, that when present, allow us to assume conditions of quality.

4. The selected indicators (evidence of performance) should be easily verifiable, whenever possible by observation alone (yes or no), avoiding standards whose evaluation implies extensive reviews of documentation.

5. The standards will provide for evaluation, within a single service, aspects of structure, process, and results (or outcomes), which reflect the benefits of quality. Although the evaluation of results offers many difficulties, given that the evaluated hospitals do not carry it out themselves, the evidence of performance preferably should allow consideration of structural conditions existing prior to medical intervention, as well as the quality with which the process of care evolves.

6. The range of the standards may go from an acceptable level of quality, up to an optimum, which may be present in some hospitals in the Region. The optimum should not be ideal, but the best that the existing conditions permit (Level 3 or 4 in the Manual).

7. The different degrees of satisfaction of a standard should be correlated among themselves; they should not correspond to different features in parallel hierarchies. The higher degrees of satisfaction imply fulfillment of the lower degrees.

Concerning the hospital of certain standards, it is desirable to comment as well on some additional concepts:

1. The services of critical medicine, intensive care, as well as neonatology, depend substantively on the available technological infrastructure and, in particular, on the concentration of the technology in each theatre of intensive care. In this case, the different levels of satisfaction of the standards reflect, in part, degrees of technological complexity of the service, although some aspects of quality in the process of medical care have been considered, the content is a description of the existing equipment. In some cases, such as the resuscitation unit or normal newborn care, the features overlap with activities required for the standards for emergency care and childbirth care, respectively. This overlapping expresses the “compulsory” and “facultative special services” aspects of those areas, as we will see further ahead.
2. The standards for radiation therapy and nuclear medicine are sensitive to the technological infrastructure; besides that we have sought to include aspects of quality in the process of medical care.

3. Anaesthesiology should be considered a basic and compulsory service; however, in practice anaesthesiology functions as an undifferentiated dependency of the surgical service. In some countries, nevertheless, both intensive care and responsibility for patient clinical care during surgery depend on this service. When they function in an undifferentiated manner within the surgical service, and include responsibility for the care of cardiovascular complications during surgery, that care is the responsibility of cardiologists and not of anaesthesiologists.

Interdependence of standards

This title contains a set of requirements that arise from the need for the hospitals to function as a harmonious group of services and, in turn, as part of a local network of integrated hospitals (the district health system). To define these interdependent needs, it is useful to take into account three organizational concepts:

- The comprehensive development of the different components of a hospital improves organizational efficiency and avoids disproportionate growth of some service unsupported by an adequate technical infrastructure in the institution as a whole.

- The concept that should define the categorization of hospitals is the risk of medical care, instead and before technological complexity, so that the institution is prepared to absorb a specific level of risk and refers the cases that exceed it.

- The district health system approach, as a system, leads to considering services as part of the hospital when they are really outside its physical plant. This happens in spite of different ownership of these services, so that local availability of services is a hospital institution resource, which should be included in the evaluation, as for example, in the case of a hospital purchasing outside laboratory or radiology services.

In general terms, as it is expressed in the instructions for the interpretation of the manual, the “horizontal” coherence of the levels of satisfaction of the different standards expresses a primary approximation of interdependent requirements. In addition, the services of critical medicine, intensive care, and neonatology raise the issue of a set of requirements with respect to available diagnostic media. Surgery, the emergency service, and related services add a set of interdependent requirements that should be taken into account.

The hospital context of health care

1. Scope of Application

This Manual considers each hospital, regardless of its denomination, dedicated to providing medical care, inpatient and outpatient, whether public, private, military, or a branch of social security, of greater or lesser complexity, with or without profit among its institutional objectives, and open to the entire community in its area of coverage or with admission limited to a sector of it, as a hospital.

Following a systemic approach, hospitals form part of a health care service network, associated geographically, either through a planned organization or as a result of a spontaneous arrangement of existing health care delivery factors. This criterion, including all of the service delivery facilities in a specific “catchment” area, is called “district health systems.”
2. The Patient as a Focus of Hospital Care

The development of Quality Assurance programs is a necessity in terms of efficiency and an obligation in ethical and moral terms. All hospital institutions, given that their basic mission is to benefit the patient, should be concerned with ensuring continuous improvement with a view to achieving the harmonious integration of the medical, technological, administrative, economic, and care areas and, where applicable, the teaching and research areas as well.

Unlike other industries, in a health institution or hospital the input is the patient, when s/he is ill and what the institution is expected to deliver is health. Consequently, the concept of “human being” is fundamental to the existence of these institutions, which can only have true significance when they are conceived to be for and at the service of mankind.

It is a patient whose body does not function properly; it is a person who becomes ill, who suffers, who becomes unbalanced, whose capacities, personal development, or societal relationships are weakened. It is that individual who provides the “raison d’etre” to the health entity.

A hospital manual acquires true meaning when the criteria for evaluation of the various areas are determined, using as a foundation the concept of the institution as a place for the recovery and treatment of profound human values. This concept must include the awareness of all the active participants in the restoration of health and that they are treating human beings; they recognize that their function is to help relieve human pain, suffering, and imbalances.

3. Patient Rights

Access to care

Every individual should be given impartial access to care without considering race, religion, sex, national origin, or provisions for payment of the care.

Respect and Dignity

The patient has the right to receive respectful care at all times and under all circumstances, as recognition of his/her personal dignity.

Privacy and Confidentiality

The patient has a right to privacy with respect to his person and to information, such as is manifested in the following rights:

- The right to refuse to speak to or to see someone, including visitors and persons officially related to the hospital, but not involved directly in his/her treatment.

- The rights to wear appropriate personal dress, as well as other symbolic or religious objects, whenever they do not interfere with the procedures for diagnosis or treatment.

- The right to be examined in installations designed to ensure reasonable visual and auditory isolation. This includes the right to request that a person of the same gender be present during certain parts of a medical exam, or during treatment or procedures done by a professional of the opposite gender. This includes the right not to remain undressed for more time than necessary for carrying out the medical procedure for which s/he was requested to undress.
• The rights to expect that every consultation or mention of his/her case is made discreetly and that there are no people that are not directly involved in his treatment present without his consent.

• The right to have his/her medical records or files read only by those directly involved in his/her treatment or those who supervise its quality, and by other persons only with his/her prior written authorization or that of his/her authorized legal representative.

• The right to expect that all communication and records pertaining to his/her treatment, including the provision for payment, are treated confidentially.

• The right to be provided with the isolation and protection considered necessary for his/her personal safety

• Any other right as defined by local law and regulation.

Personal Safety

The patient has the right to expect reasonable security to the extent that the practices and installations of the hospital allow.

Identity

The patient has the right to know the identity and the professional position of the individuals that are providing him/her services, as well as the right to know which physician or health professional is mainly in charge of his care. The participation of a patient in clinical training programs, or for the purpose of obtaining information for research, should be voluntary.

Information

The patient has the right to obtain from the professional responsible for the coordination of his/her treatment the complete updated information on his/her diagnosis (to the extent that it is known), his/her treatment, or any prognosis. That information should be communicated to the patient in such a way that s/he can be expected to understand. When it is not considered medically advisable to give this information to the patient, that information will be made available to an authorized individual.

Communication

The patient has the right to access to people from outside the hospital through visits and oral and written communication.

When the patient does not speak or understand the predominant language of the community, s/he should have access to an interpreter. This is of particular importance when such language barriers represent a continuing problem.
Consent

The patient has the right to be reasonably informed about, and participate in, the decisions related to his/her health care. Whenever possible, this should be based on a clear and concise explanation of his/her condition and of all the implicit technical procedures, including the possibilities of any risk of death or serious reactions and of problems related to his/her recovery and a satisfactory outcome. The patient should not be subjected to any procedure without his/her voluntary, competent, and conscious consent, or that of his/her legally authorized representative. When there are significant medical alternatives for treatment, the patient should be so informed.

- The patient has the right to know who is responsible for authorizing and carrying out the procedures or the treatment.
- The patient should be kept informed if the hospital is proposing to carry out or to undertake human experimentation or some other educational or research project that would affect his/her health or treatment. In addition, the patient has the right to refuse to participate in such activities.

Consultations

Under request and at his/her own expense, the patient has the right to consult with other specialists.

Refusal of Treatment

The patient can refuse treatment to the extent permitted by law. When the refusal of treatment by the patient or his/her legally authorized representative interferes with the provision of adequate treatment, according to professional standards, the relationship with the patient will be terminated with reasonable prior advance notice.

4. Responsibilities of the Patients

Supply of Information

The patient has the responsibility to provide, according to his best understanding, precise and complete information on his/her current complaints, previous diseases, hospitalizations, drugs, and other matters related to his/her health. The patient has the responsibility to report any unexpected change in his/her condition to the responsible professional. The patient is also responsible for reporting whether s/he understands clearly the course of action.

Compliance with Instructions

The patient is responsible for following the plan of care recommended by the professional mainly responsible for his/her care. This can include following the instructions of nurses and other personnel, associated with his/her care in the implementation of the coordinated health plan, carrying out the orders of the responsible professional, and adhering to the regulations and statutes of the hospital. The patient is responsible for keeping his/her appointments and, when this is impossible for any reason, for notifying the responsible hospital professional.

Refusal of Treatment

The patient is responsible for his/her actions if s/he refuses to receive treatment, or if s/he does not follow the instructions of the practitioner.
Regulations and Statutes of the Hospital

The patient is responsible for observing hospital regulations and statutes that relate to his/her care and the behavior of the patient.

Respect and Consideration

The patient is responsible for being considerate of the rights of the other patients and hospital personnel and for helping to control noise, smoke, and the number of visitors. The patient is responsible for respecting the property of other persons and of the hospital.

Preliminary instructions and procedures

Conditions for requesting accreditation

To request accreditation, the hospital applying should meet all the following preliminary requirements:

- It must be licensed by the appropriate health authority.
- It must have been in continuous operation, legally licensed, for at least one year.
- It must maintain its installations in operation 365 days a year.
- It must maintain installations, beds, and services continuously available 24 hours a day.
- It must have its own medical staff that always guarantees continuity of the care.
- It must ensure that all professionals, who have access to the use of its installations, are licensed to perform their specific activities.

Recommendations for procedures for requesting accreditation

To request accreditation, the hospital should the national accrediting body in writing and in accordance with the following standards of procedure:

- It should complete an application form in which the preliminary requirements stated in the previous section are verified.
- It should pay the cost of the evaluation in accordance with the fee stipulated by the evaluating entity.
- Before the evaluation, the hospital will receive the Accreditation documents that will be to be used for the accreditation.
- In advance, the authorities should communicate to the public, the personnel, and the patients, plainly and clearly, that during the times stipulated the surveyors that will carry out the survey will visit the hospital.
- The public, personnel, and admitted patients should be instructed to respond to all the requests of the surveyors.
At the end of the surveying process, the surveyors will report the results of the application of the evaluation instrument, and the decision that they will recommend to the accreditation body. In addition, they will advise the hospital concerning the objectives toward which it should orient its investments in the immediate future, in accordance with the instructions for interpretation.

The final opinion will be communicated by the accreditation body to the authorities of the hospital confidentially. The right to make the results of the evaluation public will remain exclusively with the hospital.

The results of the evaluation can be appealed before the highest authority of the accreditation body, which will issue a final opinion that can not be appealed.

**Implicit conditions of quality before applying for accreditation**

The methodological characteristics for setting of standards of quality in developing countries are oriented toward analysis of some indicators representative of the evaluated services and not toward describing the totality of the conditions of quality required. This difference between the exhaustive description and the most representative data, selected in relation to the cost-benefit ratio of the evaluation, requires pointing out some elementary requirements not included among the quality indicators, but that should be considered implicitly required conditions in every hospital. Among such conditions the following are cited as examples:

- Walls that are peeling or have deteriorated plaster.
- Rough surfaces in areas of restricted circulation (operating rooms, sterilization, intensive therapy, etc).
- Dripping or moisture on the ceilings and/or walls, neglected.
- Interrupted or restricted water supply during some part of the day.
- Building located in a flood-prone area.
- Deteriorated or old paint on the walls and woodwork.
- Domestic animals within the building, presence of roaches or rodents.
- Uniforms of the staff dirty, shabby, or in disarray.
- Trash and/or garbage accumulated outside the places designated for it.
- Lack of installations for the vertical circulation of stretchers and wheelchairs (ramps, elevators) in hospitals with more than one story.
- Others.

**Instructions for the use and interpretation of the manual**

These instructions are to establish the criteria by means of which the final result will be determined, based on evidence of performance and taking into account that the set of the data collected should lead to a
concrete decision on whether the hospital accredited or not. These standards are orienting and are subject to revision by those responsible for the program in each country, in accordance with:

- The policies within which the evaluation procedure is framed.
- The local reality in the health services.
- The levels of development of the existing hospitals.

The manual is composed of two groups of standards, compulsory and facultative standards. The standards included in the first group should be considered minimum and compulsory for every hospital. Those included in the second group will depend on the existence or absence of the service in the evaluated institution or on the decision of the region to include them among the standards.

All the standards are organized on increasing correlated levels of satisfaction; to achieve a higher level of quality, the previous levels should have been achieved. To determine the level agreed upon for every standard (Level 1 to Level 3 or 4), the evaluation should be initiated at the lower levels and continued up to the level whose requirements are not totally met. For every standard one should consider as verified the level whose requirements are met completely; the requirements are indivisible when they refer to more than one quality: if one of these is not met, the satisfaction of the previous level should be pronounced as achieved.

For every interpretation of the results of the survey, in applying the set of compulsory minimum standards, the following criteria should be considered:

a) To be accredited, the hospital should achieve, at least, the satisfaction “Level 1” for all the standards.

b) When one to three standards of the accreditation requirements are not completely met, because of deficiencies that can be corrected within a year, a provisional certificate of accreditation can be granted for that period.

c) The standards have the same value and no standards can be waived.

d) The purpose for the different levels of satisfaction of the standards is the promotion of comprehensive development of the hospital, leading to the coherence of inter-related service quality. The levels are for exclusive internal use of the evaluating entity and of the authorities of the hospital; they do not have public status.

e) The advice given by the surveyors to the authorities of the hospital should be oriented at the manner of channeling investments to achieve greater “horizontal” coherence in the levels of satisfaction of the different services. One should take into account that the levels refer to satisfaction of requirements for accreditation.

f) A full certificate of accreditation will be granted for two or three years; at its termination it should be renewed. Provisional certification will be for one year; depending on whether or not deficiencies targeted in the evaluation have been overcome. The hospitals not accredited should wait at least one year before requesting a new evaluation.
g) Successive surveys will involve a progressive increase in the levels required. In this regard, the different degrees of satisfaction serve the purpose of orienting the objectives toward which the hospitals should direct their efforts for improvement in the future.

MINIMUM STANDARDS

Organization of medical care

1. Patient care

Implicit condition: All individuals permitted to provide patient care services independently in the hospital are licensed.

Level 1: It has a medical directorate that administers the care and assumes responsibility for it as well as for its supervision. The continuity is based on the physicians on duty. It has professionals specifically charged with follow-up of the admitted patients, with daily tours of the wards.

A professional staff member manages the medical care, supervises the decision-making concerning diagnosis and treatment, and assumes final responsibility for the medical procedures adopted. The establishment has physicians on duty 24 hours a day; they are responsible for the care of the hospitalized patients when there are no other medical personnel in the institution. The responsible physician should be questioned concerning the system by which continuity of medical care is guaranteed when the physician in charge of each patient is not present. Request should be made in the office of personnel for the list of assigned physicians, with their distribution by day and hour, in every case the registration of the certification of the physicians on duty should be verified. In every wing, department, floor, or sector, there are part-time professionals that are responsible for the follow-up of the admitted patients, in addition to the physicians on duty in the emergency service and the intensive care service. These professionals visit all the beds daily and update the decisions. The responsible physician should be asked the schedule on which these rounds are made and adherence to it should be verified, checking the medical records.

Level 2: Responsibility for each patient is assigned to a professional in the establishment, through whom all the indications of the specialists are channeled.

Every patient has a chief clinical physician and a resident or a member of the permanent staff assigned to him/her; all the indications of the specialists are channeled through him. If the chief physicians are residents they should have continuous supervision, if they are on the regular staff they will be under the direction of clinical medicine. The responsible physician should be questioned on the application of this system, and the chief physicians on the degree of adherence to this standard in the daily activities.

Level 3: The medical staff discusses the cases in clinical meetings, held no less frequently than once a week.

At least once per week the medical staff, in plenary session or by sector, holds a clinical meeting to discuss the most relevant cases. The person responsible for the organization of the meetings should be questioned on the mode of operation and the selection of cases. The clinical records of the patients

Ed. N.: Standards of each level of satisfaction have a small instructive highlighted for the evaluator and the evaluated. These are evidence of performance or qualitative indicators of the standard (in "italic"). The detailed instructions should be further developed for the evaluation committees of each EMR country.
discussed in the forums should be checked to see whether the decisions adopted at those meetings were recorded.

2. Transfers or Referrals

Level 1: There are standards concerning the establishments in the district health systems, of greater complexity to which the cases that exceed its operative capacity should be transferred. It has mechanisms for transfers to establishments of lesser complexity of the cases that have passed the critical stage.

The patients covered by some financing entity usually have a list of services under contract to which they should be transferred for the purpose of specialized diagnostic studies or procedures of greater complexity than those existing in the establishment where they are served. When this does not occur, the emergency service should have precise indications concerning the establishments to which the cases with different needs that can arise on a shift should be transferred. The physician on duty should be asked about the existence and easy accessibility of the list of reference centers should be verified. That list should contain at least one more general hospital with neonatology, neurosurgery, traumatology, ophthalmology, and intensive care services. The room physicians have a list of establishments for lesser degrees of risk, located in the hospitals’ area of influence of the district, to which the recovered cases that reside in suburban or rural areas can be transferred. Such establishments maintain good communications with the referring establishment through contacts among physicians by telephone or radio or any other available communication means.

Level 2: A means of transport with or without the following elements should be available:

- Medical care.
- Equipment for critical care and life saving medicines.
- Incubator for transportation.

It should also have precise indications concerning the means of transfer of patients to other establishments. One should also ask the physician on duty and verify the existence and accessibility of the list. It should also be ascertained, by means of a telephone consultation, whether the institutions listed do indeed offer the services listed.

Level 3: There are written policy and procedures for the initial care and during the transfer for the principal serious acute illnesses, and also discrimination of referral establishments depending on the pathology to be transferred.

The standards should contain the initial indications of diagnosis and treatment, as well as the most appropriate form of transfer, for at least the following clinical syndromes:

- complications of pregnancy and delivery
- Serious acute respiratory failure: laryngeal syndrome, hypertensive pneumothorax.
- Serious acute circulatory failure: acute pulmonary edema, pulmonary embolism, serious acute arrhythmia, shock.
- Acute suprarenal failure.
• Serious acute psychiatric syndrome: delirium tremens, acute schizophrenia.
• Acute pancreatitis, digestive hemorrhage, acute abdominal symptoms.
• Neurology-acute neurology: strokes, epilepsy crisis.
• Trauma

Those policies and procedures should be easily accessible, within the reach of the physician on duty, and should provide for the necessary measures to make the initial differential diagnosis of every case and provide the essential care that would make it possible to transfer the patient. Similarly, it should indicate the most desirable place to transfer every type of pathology.

Level 4: There is a mechanism for follow-up of the transfers and the quality of the care provided to them should be evaluated.

Through the medical management or social service a follow-up of the patients that have been transferred should be made. In the same manner there should be a determination of whether the establishment to which the patient was transferred ratified or rectified the diagnosis and course of treatment determined by those who originated the transfer; this should be recorded in the patient’s clinical record. The responsible physician and the social service should be questioned and the clinical records of the last 10 transfers should be observed.

3. Outpatient Clinics (Ambulatory Care)

Level 1: In the basic specialties there are office hours available during the day; for the rest, the waiting time is no longer than ___5___ days.

In the schedules of office hours there should be verification of the spaces reserved for office hours during the day and which specialties are provided; in addition, for the remaining specialties the anticipated waiting time for patients being seen for the first time should be determined.

Level 2: It has specialists who have the necessary means to carry out specialized practices and outpatient surgery.

There are physicians in the most important specialties in the hospital that have the means to carry out the most frequently used diagnostic and therapeutic procedures as well as the support infrastructure to carry out outpatient surgical interventions. The feasibility of the most frequently used procedures and operations should be assessed.

Level 3: The outpatient department relies on its own secretarial and nursing staff.

It should be verified in the office of personnel and with the nursing director that one secretary and one nurse are assigned to serve exclusively in outpatient clinics during the time that they are open. The exclusiveness refers to the hours of operation of the outpatient clinics, outside of which the personnel can be assigned to other tasks.

Level 4: The office hours are scheduled on the basis of guidelines set by the professionals. Appointments can be made by telephone.
The personnel charged with making up the schedule has instructions on the frequency, duration, and distribution of the consultations for every specialty. The personnel should be questioned on the telephone numbers available for making the appointments and through what media they are made known.

4. Emergency Service

Level 1: It has a physician on active duty 24 hours a day, functioning with the exclusive use of a site and nurses dedicated to the service, with Radiological, pharmacy, Laboratory and Blood Bank support. To have written standards, protocols, guidelines and posters available for the most prevailing diseases.

The office of personnel should be requested to provide the list of physicians and nurses assigned to the sector and their distribution to provide adequate coverage 24 hours a day seven days a week. Confirmation should be obtained of the record of the registration of all the physicians. The site designated for emergency service should not be utilized for other tasks and should have the elements necessary for fulfilling its function: stretchers, instruments for sutures and dressings, and drugs for emergencies.

Level 2: It has the following specialties on call: clinical medicine, general surgery, obstetrics and gynecology, and pediatrics. It has a resuscitation unit, served by personnel of the emergency service. For specialized hospitals relevant specialists should be available on call.

The list of professionals with these specialties for every day of the week should be requested. There should be verification that list exists and is available in the service. The resuscitation unit is an area designated for the resuscitation of patients at imminent risk of death; it has the staff and instruments to allow the immediate survival of the patient until he can be moved to the intensive care service. The resuscitation unit should have appropriate drugs and disposable materials, a defibrillator, an electrocardiograph, an internal pacemaker; it will have, in addition to oxygen, compressed air, and an aspirator.

Level 3: Professionals representing at least three of the basic specialties are on active duty 24 hours a day.

There should be verification of the list of corresponding professionals and their distribution and also that they have facilities for the nighttime rest in rooms that are not utilized for patients. A hemodynamic monitor and a respirator should be available.

Level 4: It has professionals representing at least two additional specialties on call 24 hours a day, with access to the equipment of the corresponding service.

There should be verification of the list of corresponding professionals and their distribution and also that there are keys for the respective services in the general key cabinet and that they are accessible to the night shift. It should be verified that the telephone numbers recorded allow rapid contact with the specialists on call. Educational levels are essential at this level.

5. Clinical Laboratory

In order to consider that the laboratory forms part of the evaluated establishment, regardless of who has title to the equipment, it should be located in the same building or at such a distance that the trip there and back on foot takes less than 30 minutes. There is a formal relationship between the laboratory and the establishment.

The laboratory tests listed in the Annexes are only indicative for the regions.
Level 1: a) It can process, without delegating to another laboratory, the analyses listed in Annex A, and it has a technician and/or biochemist on active duty 24 hours a day. The service should comply with the basic laboratory procedures on safety.

Without delegating means that all phases of a determination are carried out within the laboratory itself. There should be verification of the existence of the necessary reagents and their expiration dates, and there should be an evaluation of their consumption through the respective purchase invoices or other available documents; the consumption should coincide reasonably with the billing statistics in the financial entities. There should be verification of the list of technicians and/or biochemists on call as well as the effectiveness of the communication system which should permit the arrival of the responsible person at the laboratory in less than 30 minutes.

b) Hemotherapy service is available nearby, from which it obtains blood within a period of not more than one hour, and it meets the standards of communicable disease control. There is a formal relationship between the service and the establishment. It has plasma expanders on hand. The service should comply with the basic laboratory procedures on safety.

The distance between the nearby service and the evaluated establishment should make it possible have blood in less than an hour by the usual means of communication. It should have the means for carrying out the compulsory immunohematologic tests:

- Group and Rh factor in the receiver.
- Group and Rh factor in the blood donor.
- Compatibility tests.

Level 2: It can process without delegating to another laboratory, disk antibiotic sensitivity tests and biochemical identification of pathological microorganisms. The individual responsible for the service controls the operational quality of the determinations through the supervision of the procedures used and the continuous instruction of the personnel in his charge.

There should be verification of the existence of antibiotic sensitivity disks and of reports done previously and also of the existence of an incubator for cultures, different culture media, and adequate glassware. The individual responsible for the service and the personnel should be questioned about the measures adopted to control the quality of the laboratory services. There should be verification that guidelines on biochemical procedures are available and that personnel meetings are held to discuss them; the frequency with which the responsible individual personally supervises the steps of the determinations should be ascertained.

Level 3: It can process, without delegating to another laboratory, blood gases and quantitative antibiotic sensitivity tests. It has technicians and/or biochemists on active duty 24 hours a day. The control of the operational quality of the laboratory services is the responsibility of the individual responsible for the service and is carried out through running control samples periodically.

There should be verification of the presence of the technician and/or biochemist on active duty, as well as the list of the night shift provided for each day. There should be verification of the availability of facilities for their nighttime rest in rooms that are not utilized for the hospitalization of patients. The existence of pH meter equipment for pO₂ and pCO₂, with usable electrodes and available charges of gas should be verified. The responsible individual should be questioned on the frequency with which he carries out the controls with samples, the origin of those samples, which determinations are verified and where the results are tabulated. The records of the controls done in the three last months should be observed.
Level 4: It can process without delegating to another laboratory the analyses listed in Annex B. It adheres to an external program of quality control.

There should be verification of the existence of a manual well counter or an automated scintillation counter, containers for radioisotopes, and also a bunker for their storage. There should be a comparison, using the purchase invoices for radioisotopes, of consumption with the production statistics. Evidence of a license to use radioactive material, issued by the competent authority in the jurisdiction that corresponds to the establishment, should be requested. The certificate of registration in the program for quality control should be seen. The responsible individual should be questioned on the frequency with which samples are received, on determinations, and on communication of the observations. There should be verification of copies of the records of the results from the last three months.

Annex A:

- Serum amylase test and complete urine analysis
- Bacterioscopy (tuberculosis)
- Basic coagulogram
- Cholesterol
- Creatinine
- Pregnancy test
- Acid phosphatase and alkaline phosphatase
- Gram, Giemsa staining
- Blood glucose
- Blood group (ABO and Rh)
- Complete blood picture
- Blood Film for Malaria
- Complete urine analysis
- Complete stool analysis
- Total protein
- Coombs test
- Occult blood in feces
- Clotting time and bleeding time
- Prothrombin time
- Triglycerides
- Uremia
- Sedimentation rate
- Qualitative VDRL
- Others

Annex B:

- Australia antigen (Au antigen)
- Carcino-embryonic antigen (CEA)
- Antistreptolysin O
- Calcemia
- Creatine phosphokinase (CPK)
- Estriol
- Ferremia
- Follicle-stimulating hormone (FSH)
- Lactic dehydrogenase
- Latex
- Luteinizing hormone (LH)
- Prolactin
• C-reactive protein
• Thyroxin (T4)
• Tri-iodothyronine (T3)
• Thyrotropin (TSH)

Blood urea
Blood culture
Pop smear
Prostate specific antigen
Tumor mark
Others

6. Diagnostic Imaging

National or international standards for radiological protection should be followed.

Included under this title are the following procedures:

• Radiology: conventional, linear tomography, by digital subtraction of images, mammography, computerized axial tomography (CAT), etc.

• Ultrasonography: mono-and bidimensional sonography, studies through Doppler effects, etc.

• Nuclear medicine: fixed-head scintiscan (gamma chamber) or mobile-head (linear) scintiscan.

• Photon-emission computerized tomography and positron-emission computerized tomography.

• Others: magnetic resonance imaging (MRI), thermography.

Level 1: The unit is certified in accordance with the requirements of the health physics service of the corresponding jurisdiction. It has fixed equipment, from at least 100 mA, with a Potter Bucky device without serialograph. Basic radiological system (BRS) recommended by WHO. A radiologist is not necessary.

The certificate of qualification, issued by the health physics service or the corresponding jurisdictional authority, should be requested; it should be exhibited in a visible place. Fixed equipment is that which is not movable but is left in place, once installed (study table, generator, support for X-ray tubes, etc.). It should have a Potter Bucky device.

Level 2: It can do contrast radiological studies via radioscopy. The studies are interpreted by specialized physicians who exchange opinions with the attending physicians. A radiologist is necessary.

It has equipment with greater than 200 mA, with serialograph and radioscopy screen, or with an image intensifier and closed-circuit television. The service has, at least, a site for the studies, space for preparation and dressing of the patients, a site for developing, and a site--with negatoscope and file

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2 Editors’ note: These standards were established as examples and do not try to establish reference standards about specific technology. Each EMR country should make its respective adaptations.
space—where the reports are prepared. Request should be made in the office of personnel for the history of specific training of the individual responsible for the service. There should be verification in several reports of the constancy of the signature of the specialist. The physicians of the establishment should be asked if they exchange opinions with the specialist frequently, if there is a formal or informal mechanism (forum) for that exchange, and if the physicians gather frequently in the service in order to view the studies.

Level 3: It functions a full 24 hours a day, with a radiological technician and a radiologist on duty. It has portable radiological equipment for studies in the wards or operating rooms. It has the personnel and auxiliary equipment necessary for carrying out invasive procedures under fluoroscopic or sonographic control. It has a gamma chamber and CT or MRI. The specialists in the service are involved in the indication of the diagnostic medium most appropriate for each case.

In the office of personnel the list of technicians and physicians should be verified, with their hourly schedules and the rotation of the shifts. There should be verification in the records of the service of the existence of reports covering the hours between 10:00 p.m. and 6:00 a.m. The existence should be verified of at least one portable radiological device, with facilities for moving it to carry out studies in both patients’ rooms and in operating rooms. It should have sufficient resolving power to do intra-operational cholangiographies. In the service there are the personnel (support nurse on call) and the necessary equipment (glass cabinet with instruments, drugs and disposable materials, garments for sterile protection, dressing cart) to carry out invasive studies under fluoroscopic or sonographic control, such as endoscopies, aspiration punctures, and biopsy punctures. The assigned personnel have the training to transform the site into an aseptic environment. The personnel of the service should be questioned about the frequency with which these procedures are carried out and the steps that should be carried out in order to accomplish them. Procedures for intravascular or hemodynamic catheterization are excluded.

The specialists in the service are consulted, in tours of wards and forums, on the diagnostic medium most appropriate for each case and are subsequently involved in the interpretation of the different studies. The specialists in the service and the ward physicians should be questioned about this mode of operation with the aim of establishing whether an integrated concept of diagnosis through images and free exchange between this service and the attending physicians exist.

7. Care at Birth

Included in this category is the set of services designated for the care of pregnant women and children and, in particular, the aspects related to the moment of birth. The different components of the area are unified by health and functional factors, although they are not especially concentrated within the physical plant.

Level 1: It has an obstetrical nurse (midwife) on duty and an obstetrician and a pediatrician, who are on call. The births are attended in a differentiated delivery room. The hospital is committed to the national and/or global promotion health programs. These include but are not limited to Baby Friendly Hospitals and Expanded Program on Immunization.

The emergency unit should be asked for the list of professionals available each day of the week and the means of communication through which they can be called. There should be verification that by these means the professional can be located in less than one hour. There should be verification in the office of personnel of the record of specialized training of each professional. It has a site designated exclusively as a delivery room; it will have a delivery table or chair, adequate illumination, nursing support, instruments, drugs and disposable materials in glass cabinets and cupboards, and also an adjoining washroom.

The care provided by the health staff for mothers and infants meets global criteria of Baby Friendly Hospitals and Expanded Program on Immunization.
Level 2: It has obstetricians on duty and an anesthetist and pediatricians on call and there is an exclusive site for reception and resuscitation of the neonate, with the necessary elements to assist a high-risk pregnancy, with pre and perinatal monitoring. It guarantees adequate minimum care for the neonate and its mother up to their transfer to a center of greater complexity.

There should be verification in the office of personnel of the list of professionals assigned, the distribution of their hours, their assignments on rotation, and the records of their previous specialized training. The site devoted to the reception of the newborn is air-conditioned at the proper temperature, is contiguous to the delivery room, and is provided with hot water 24 hours a day; the newborn can be bathed if it is necessary. It has a blood bank facility, laryngoscope, a baby scale oxygen, an aspirator, and compressed air; it has an incubator for transport. If necessary, the mother can be transferred rapidly to a neighboring operating room, (see standards for the surgical area).

Level 3: It has a trained pediatrician in neonatology or neonatologist on call. It possesses a sector designated for the care of the pathological newborn, clearly differentiated from the section for normal newborn, which can resolve the principal respiratory syndromes of the newborn, including the need for mechanical respiratory assistance.

The different environments of the area for care of the pathological newborn constitute a differentiated functional unit, located in an area with restricted circulation. This section has its own nursing station. It possesses all the equipment necessary for: resuscitation, blood exchange, drainage of the pneumothorax, channeling of umbilical artery, and central venous pressure. It has equipment for light therapy, neonatal mechanical respirators, transcutaneous oxygen monitor, oximeter, continuous positive pressure equipment, and a pump for negative aspiration. The medical team holds weekly forums and reports, upon request, to the parents on the evolution of each case.

8. Surgical Area

Level 1: It is in an area of restricted circulation, differentiated and exclusively designated for this purpose. It has, at the very least, a support site for washing, nurses, and final gowning of the surgical team. There are standards for preparation and/or maintenance of the operating rooms and the necessary materials are available. There are surgical and anesthetic protocols for each operation. There is a standardized procedure for cleaning operating rooms between operations.

The area of restricted circulation is separated from the rest by a door that is kept closed, with signs prohibiting entry. The section for hand-washing by the surgical team has a faucet and dispensers of soap and/or antisepsics that permit their management without utilization of the hands. Personnel that come from other areas of the establishment are not admitted to this support section without having changed their clothes and put on the proper clothing for the surgical area. The nurse should be asked for the instructions with the standards for preparation and/or maintenance of operating rooms; there should be verification of the existence of clean glass flasks for this purpose, formalin, alcohol, and every other item indicated in the instructions. In a sample of 20 clinical records, taken from the service record book, of patients operated on during the last three months, the presence of the surgical and anesthetic operative records in 100% of the cases should be confirmed. The operating rooms are cleaned with water and detergent after each operation.

Level 2: It has two operating rooms and there is at all times at least one person designated exclusively for the surgical area.

The personnel assigned exclusively to the surgical area is a member of the nursing staff and sees to the arrangement of the instruments and other surgical items; s/he controls the receipt and dispatch of these materials when they are sent for washing and sterilization; s/he controls the disposal of the refuse and solid
wastes outside of the surgical area; during his/her shift s/he does not perform any function not related to the area; s/he is responsible for the adherence to the standards of asepsis, both in operating rooms and in the adjoining areas, even with respect to the physicians.

Level 3: The surgical area is coordinated by a professional. It has a site designated for recovery from anesthesia. The dressing room for the staff has a differentiated access. There are facilities for intra-operative radiological diagnosis. The intra-operative monitoring of patients at increased risk is carried out by medical specialists.

The individual responsible for the surgical area fulfills the following functions:

- Supervision of the work of the nursing personnel.
- Scheduling the tours of duty and distribution of the operating rooms.
- Controlling the adherence to the standards for the prevention of infections.
- Determination of the needs for provision of items for surgical use (instrumentarium, drugs, disposable materials, antiseptic, and various supplies).

The size of the site for recovery from anesthesia should be related to the available operating rooms, at a rate of one bed for every two operating rooms; it can be divided into cubicles. The anesthetists control the recovery of the patients already operated on and indicate the moment of transfer to the appropriate service in the hospital. The nursing personnel should be asked on the fulfillment of this requirement. Patient traffic is not crossed with that of the surgeons, anesthetists, and instrument nurses. There is a transfer area that prevents the entry to the surgical area of stretchers and personnel from the rooms for hospitalized patients; access to the dressing room is differentiated and one can enter from the exterior of the surgical area or from the transfer area. There should be verification of the existence of radiological equipment for intra-operative diagnosis, which should be in operable condition and have personnel, adequately protected from radiation, available to operate it. The names of professionals that performed intra-operative monitoring of patients with increased cardiology risk should be copied from the operating room book and their specialization in cardiology should be verified in the office of personnel.

Level 4: The operating rooms are differentiated and equipped by specialty. There is an operating room for the exclusive use of the emergency service.

The individual responsible for the distribution of the operating rooms in the surgical area should be asked and the specialties for which they are designated should be ascertained. It should be determined whether they have specific equipment for every specialty, such as a pump for extra-corporeal circulation in the room for cardiovascular surgery; a microscope in that for neurosurgery, an orthopedic stretcher in that for traumatology. In the surgical service book the appropriateness of the cases operated on with respect to the designation of every operating room should be evaluated. The emergency service operating room can be annexed to that service and thus separated from the surgical service; in this case, it should at least meet the requirements of Levels 1 and 2.

9. Anesthesiology

Level 1: The anesthetists respond to the demands of the surgeons. They prepare the anesthetic protocol. It has a list of anesthetists on call, organized for every day of the week. Pre-anesthetic visits should be carried out.
In the surgical service there is a list of anesthetists with their respective means of communication. There should be verification of the existence of the list in the surgical service and also that the named professional is available at the time of the evaluation. The pre-anesthetic visits should be verified in a sample of clinical records. In a random sample of 20 clinical records of patients operated on during the last three months, there should be verification of the existence of an anesthetic protocol in 100%.

Level 2: It has a service of anesthesiology, under the direction of a responsible individual that coordinates the shifts and anesthetists on call.

There should be verification of the specialized training of the individual responsible and the anesthetists on duty, in the office of personnel. The scheduling of the shifts and the adherence to the schedule on the day of the evaluation should be observed. The orders for supplies and drugs placed by the individual responsible for the service during the previous month should be reviewed.

Level 3: The shifts are covered by on-duty anesthetists and medical residents in the specialty (who act as auxiliaries) or auxiliary technicians.

In addition to the specialists, it has residents in the specialty who see the preparation and sanitation of the instruments as well as the induction of anesthesia. In the places where there are courses for auxiliary technicians in anesthesiology, one can allow their inclusion in the evaluation under the functions mentioned for the residents.

10. Hospital Infection Control

Level 1: It has written standards for precautions for the control of infections and part time responsible nurse (infection control officer).

The responsible physician and the individual responsible for nursing should be questioned on the availability of written standards for infection control. There should be verification of the accessibility of these standards and the physicians, nursing personnel, and cleaning staff should be asked whether they have received some special instruction on this subject within the establishment. The standards can be official, from a scientific publication, or prepared in-house and endorsed by the hospital authorities. Appearing among their contents should be recommendations concerning such subjects as: hand-washing, antiseptics and disinfectants, hospital hygiene, isolation precautions, universal precautions with blood and body fluids, dressing of wounds, and care of intra-vascular and urinary catheters and those for respiratory support and obstetric procedures.

Level 2: Records are kept of the incidence of hospital infections or prevalence studies are conducted at least once a year.

The authorities should be questioned on the type of follow-up performed, the criteria for classification, the method used for information collection, and the person responsible for the data processing and analyses. The existing written reports on the studies carried out should be requested. The records of incidence should contain information on the number of cases detected in a specific period, the mode of infection, and the relationship with the number of hospitalizations. The studies of prevalence should contain the number of existing infected patients in one day in relation to the total number admitted, the distribution per room, and the means by which the infection was diagnosed.

Level 3: It has at least one person, a nurse or other professional, responsible for infection control, who applies active epidemiological surveillance methods.
The authorities should be questioned about: their level of professional training, functions that they fulfill (in addition to that of infection control), their decision-making power (formal and real), and tasks that they usually carry out. The person responsible should be questioned about the effect that his/her activities have, the attention that s/he receives from his/her superiors in response to the problems s/he presents, and the general scheme of work followed. Previously written reports should be checked.

Level 4: It has an infection control committee and a program for prevention and control of hospital infection that is revised annually.

The authorities should be questioned on the composition of the committee, who performs the coordination or functions as the secretariat, the linkage with the highest authority of the establishment, and the frequency with which meetings are held. The proceedings or records of the meetings held during the last six months and the subjects treated should be observed. The program for epidemiological surveillance, if there is such, to which the committee's objectives are adapted, should be requested. There should be evaluation of the components of the program: records of infections, identification of the prevalent strains, standards of antibiotic therapy, continuing instructions to personnel, and surveillance of cleaning procedures and invasive techniques for diagnosis and treatment. The program for epidemiological surveillance appears in the annual report of the establishment.

General and support areas

11. Food Service

Level 1: It has a list of diets categorized by disease, prepared by a dietician or nutritionist. Not less than 50% of a sample of patients rates the food as satisfactory.

The physician responsible for the areas of hospitalization should be asked on the system by which the diets are prescribed; there should be verification that professional has a list of standard diets for the principal pathologies and that these are detailed with their nutrient composition, their dietetic prescriptions, and their daily menus. The list should contain diets at least for: gastro-duodenal ulcer, diabetes, post-cholecystectomy, and renal failure, as well as a soft diet. A dietician should be responsible for their original preparation. The individual responsible for the kitchen should be asked to verify that he has the same diets as the responsible physician. There should be verification of the relationship between the menus for the day and the different dietetic indications, in a representative random sample of not less than 20 patients. In the same sample, there should be questioning as to whether the provided food was satisfactory or not. Patients should be interviewed when checking out.

Level 2: It has a diettian for the organization of the service, the prescription of personalized diets, and daily visits to patients. It has an area for the preparation of milk formulas with specific standards (if it is medically indicated).

It should be ascertained in the office of personnel whether it has one or more dietitians on its staff that follow a regular schedule. In a representative random sample of no fewer than 20 patients, it should be ascertained whether they were visited by a dietitian during their hospitalization. The kitchen service relies on the services of a dietitian who is charged with planning the provisions of appropriate food material, the organization of the food for each day, and the supervision of the quality of the food that is presented to the patients. The same sample of patients should be asked about the quality of the food received. In the area of pediatric hospitalization, there is a special site where milk formulas are prepared; it has specific standards for the mode of preparation of the different formulas, in language understandable by unspecialized personnel.
Level 3: There is a medical service of nutrition that intervenes in the supervision of the feeding of the nutritionally compromised patients. It has the capability of effecting parenteral and enteral feeding with a feeding pump.

The existence of a nutrition service should be verified in the medical organizational chart of the institution. The members of that service should be asked about the tasks that they be assigned specifically. Among the patients admitted during the evaluation, all the cases in which there was intervention by the nutrition service should have their clinical records reviewed and it should be determined whether the service has had a determining influence in the nutrition of the patient during the hospitalization or whether the inter-consultation was devoted solely to etiopathogenic considerations in the case. There should be verification of the existence of appropriate equipment for enteral feeding. The individual responsible for the service should be questioned about the cases served in these ways during the three last months; it should be ascertained in the respective clinical records whether the service intervened in the prescription, dosage, and supervision of the nutritional scheme provided.

12. Laundry

This standard applies to the establishment's own services, whether located within the physical plant of the establishment or not, as well as to contracted services.

Level 1: The laundering process and changing of clothing is standardized.

The personnel of the service should be asked about the standards applied to the laundering of soiled hospital linen. The text of those standards should be checked to verify that they are accessible to the personnel. Compliance with them should be observed during the laundry process and changing of clothing.

Level 2: There is a special separate system for the treatment of contaminated clothes, and sufficient provision to surgeries.

The standards require that linens contaminated with blood or potentially high-risk secretions be transferred separately in polyethylene bags. The personnel should be interrogated about this and adherence to the standards during the laundering should be observed.

Level 3: Soiled linens are removed daily throughout the year and clean ones are provided daily.

A random sample of no fewer than 10 patients that present open drains of various types and/or abnormal or pathological secretions should be questioned about their satisfaction with respect to the daily changing of the bed linen. The individual responsible for the service should be questioned about the periodicity of the removal and delivery of linens to the wards; the supervisors of nursing should be asked about the adherence to the periodicity scheduled. It should be verified that there is an adequate supply of surgical clothing, and no surgical procedures should be postponed for lack of clothing.

13. Cleaning

Level 1: All the floors are washed at least once a day, with soap, detergent. Dry sweeping is prohibited.

A random sample of 10 patients should be questioned on the frequency of the floor washing and the methods used. The personnel of the service should be asked about the basic instructions that they have received with regard to the cleaning of the floors.
Level 2: It has an individual responsible for the cleaning and the procedures are standardized, including instructions for the use of disinfectants. There are standards for the specific treatment of potentially polluting elements and/or excreta (hepatitis B, AIDS, salmonellas, etc.).

There should be verification in the office of personnel of the existence of the function and who is in charge. The existence of written standards of procedure should be verified as should their easy availability to the personnel that utilize them. The existence of those standards should be verified and it should be confirmed that they are within reach of the personnel that utilize them. The personnel of the service should be interrogated with respect to their application.

Level 3: The infection control committee and/or an epidemiologist participate actively in the preparation and supervision of the cleaning standards.

Their participation should be verified through the text of the standards and through the questioning of the personnel.

14. Sterilization

Level 1: It possesses a site where the preparation and sterilization of all the materials of the institution are carried out. It has at least an autoclave and a stove or an oven. There are written standards of procedures. Biological controls are carried out in accordance with local standards.

The site should be in an area of restricted circulation and have counters, shelves, and cupboards for the deposit of the sterilized material. It has an autoclave and a gas or electric stove or oven; the airtightness of the closing in the autoclaves and the temperature in the stoves or ovens should be checked. Sterilization should be verified by a recognized means. The written standards, which should be available to the personnel, should be observed.

Level 2: The area of the service has four sections:

- Reception and manual washing.
- Preparation and processing of materials.
- Sterilization and storage.
- Dispensing of material.

It has its own or contracted services for sterilization of thermo-sensitive material.

The sectors are differentiated and separated by doors or counters; communication to the outside of the service for delivery and reception of materials is conducted through a window or over a counter. The sterilization of thermo-sensitive material is done by a recognized sterilization of thermo-sensitive material; it’s own or contracted. The hospital is responsible for the quality of the process, which means that it carries out periodic controls of the processed materials.

Level 3: The personnel have specific training.

There should be verification in the office of personnel of the recording of the training histories; each staff member should have a certificate as a sterilization technician or have received a formal course within the hospital.
Level 4: It has mechanical ventilation equipped with high-efficiency filters. The washing and disinfection of equipment is carried out by automatic equipment. The filters should be continuously monitored for bacterial contamination. Qualified personnel should operate this equipment.

*The characteristics of the filters (of the 99.99 type) should be verified with the maintenance staff. The existence of automatic washing equipment should also be verified.*

15. **Pharmacy**

Level 1: It has a pharmacy with its own site and a refrigerator for the conservation of drugs. It is administered by the director of the establishment who provides drugs to the inpatients on a restricted schedule and controls the stock.

*The refrigerator should be connected to the alternative system of electric energy. The system for controlling the stock should be observed in order to verify, for at least 10 drugs, the correspondence between the stock listed and the actual stock.*

Level 2: There are norms of pre-surgical and vademecum antibiotic prophylaxis, which are being actualized for use of the establishment.

Level 3: It has personnel on duty 24 hours a day, pharmacists and/or technicians, for the care of inpatients and outpatients.

*There should be verification in the office of personnel of the list of professionals and technicians, the distribution of schedules, and the scheduling of the rotating shifts.*

Level 4: It has a pharmacy surveillance committee.

*The pharmacy and therapeutic committee should be composed of the individual responsible for the pharmacy, bacteriologists, and head of clinical departments. The printed standards should be observed and the knowledge that the ward physicians have of them should be verified. The purchases of drugs are programmed on the basis of the manual.*

16. **Nursing**

*There should be prior verification in the office of personnel of the total number of professional nurses, and nursing support workers that the establishment has, along with the procedures for the selection of this staff.*

Level 1: The individual responsible for the service is a qualified nurse. The vital signs of the patients admitted should be recorded as needed based on the patient’s condition in the clinical record. The nurse/bed ratio is adapted to local standards.

There should be verification in the office of personnel of the record of the diploma of the individual responsible for the service, granted by a recognized public or private institution. The vital statistics include pulse, temperature, respiration rate, and arterial pressure and the periodicity of eight hours should not apply in areas with critical patients or those with different specific indications; the recording of the controls should be made on lists beside the beds or on the nursing sheets in the clinical records. The nurse/bed ratio will emerge from the general number per shift.
Level 2: The individual responsible for the service and all of the supervisors are registered nurses. All personnel with less than one year’s service have received specific in service training. There are written standards in all the offices.

There should be verification in the office of personnel of the record of the diploma of the individual responsible and of more than half of the supervisors. The list of personnel added to the staff in the last year should be requested and consulted concerning the training received within the establishment; the instruction can have been provided by the authorities of the service for a period of not less than 15 days or through an internal course combining theory and practice.

Level 3: There is a department of nursing that is charged with the selection, training, number, and management of all nursing personnel as well as setting policies and procedures for nursing care.

The entire nursing staff is administratively under a central department. The staff assigned permanently to a specialized sector (surgical service, sterilization, etc.) is technically under the individual responsible for that sector, but administratively under the nursing authority. The individual responsible for the department reports directly to one of the directors, who is in charge of all the technical services.

17. Clinical Records

Level 1: It possesses clinical records of all persons being cared for in the hospital, both outpatients and inpatients. The clinical record is legible; it is signed by the treating physician; and it has a closing (epicrisis, summary, or discharge diagnosis). There are known and widely used standards for the preparation of medical records. More than 80% of a sample of inpatient medical records should be found to be updated to the day preceding the evaluation. It has Medical Records Supervision.

There are one or more sites where the clinical records are filed, and these are not utilized for any other administrative or health care activity.

The recording of clinical records is organized by double entry: in numerical order and alphabetical order. The retrieval of the clinical records can be carried out based on the number indicating the order of the initiation of the record or by the surname and first name of the patient, undifferentiated, regardless of the way in which the records are ordered on the shelves (by terminal digit, numerical order, or alphabetical order).

First of all, the highest medical authority in the establishment should be asked with respect to the following:

- Whether clinical records are prepared for all cases.
- The different places where they are filed.
- The administrative mechanisms for opening clinical records and their delivery to the professionals, on their orders.
- Especially, the clinical records of hospitalizations, outpatient clinics, emergency services, and principal services.
- It should be verified that a sample of 20 medical records selected from the most recent hospitalizations recorded in the book of discharges are signed, are legible, and have summaries.
The medical authority should be asked on the existence of standards, the manner in which they were disseminated, the method of instructing the professional personnel and confidentiality of patient's information. There should be verification that there are accessible copies of the standards in the physicians’ rest areas, nursing offices, etc. Several professionals should be asked on their knowledge of the standards. There should be verification of adherence to the standards in the same sample of clinical records that is described below.

A sample should be taken that is representative of the inpatient areas except those with critical patients, selected randomly, and containing not less than 20 clinical records, in the establishments of more than 20 beds. There should be verification that, in at least 80% of the clinical records’ reviewed, the evolution of the working day prior to that of the evaluation was recorded. The same procedure should be followed with the clinical records in the archives.

There are standards, disseminated and known, on the preparation of clinical records. More than 80% of sample of clinical records of admitted patients are updated to the day prior to that of the evaluation.

Level 2: There is a unique clinical record that covers both outpatient and inpatient care. There is a Committee of Medical Records auditing.

There should be verification in the clinical records of the outpatient clinic for that day of the existence of records of previous hospitalizations, as well as verification, in the same sample of clinical records mentioned for Level 1, of the existence of records of outpatient care. A unique clinical record is understood to mean the concentration of all the medical data on one individual patient in the same envelope, file, or container.

The movement of the clinical records is recorded and there is a follow-up of the route. All movements of the clinical records are recorded in notebooks, cards, or lists that show the date of removal, the name of the responsible person, the service, and the date of return. If the clinical records should be transferred from one service to another, provision is made for a report of the change of route to be sent to the archives.

Level 3: There are personnel designated exclusively for this purpose and there is access to the archives 24 hours a day.

The archives are served by personnel designated exclusively for this purpose. If during their scheduled shifts, the staff members carry out other related tasks (such as statistics, other records, shifts, etc.), they should be considered exclusive if they are always available for meeting the needs of the archives. There is a provision for service in the archives 24 hours a day, which can be verified on the list of the schedules of the personnel responsible for the service.

18. Statistics

Level 1: It keeps statistical records of at least the following data:

- Outpatients and emergency visits.
- Surgical and clinical discharges.

* Medical records should include physician and nursing admission and progress notes as well as other members of medical team, laboratory results, pathology and radiology reports and discharge summaries.
• Births (deliveries, cesarean sections, vaccination at birth if applicable).

• Average stay.

• Number of surgeries

• Deaths.

The chief of the staff has full authority to observe the statistical records and the service provided during the last calendar year. The data mentioned should be found tabulated and processed, at least three months prior to the month in which the evaluation is conducted, although they may not have been prepared for internal publication. The statistical data has been communicated with health authorities and concerned parties, as applicable.

Level 2: There is a person specifically devoted to this work, although not exclusively.

The recording, tabulation, and processing of statistical indicators are carried out by a person especially trained or assigned to this task, although he/she may, in addition, perform other, different activities. The medical authority of the establishment should be asked about his interpretation and observation of the data and the service provided during the last calendar year.

Level 3: The inpatients are classified by one of the following classifications:

• WHO classification with two or three digits.

• By principal syndrome for clinical inpatients, and by anatomical system for surgical patients.

• By precise clinical diagnosis and by the code of the operation.

Level 4: There is a department of statistics with technicians who issue a monthly publication of the information and periodic meetings are held for its discussion.

The statistics department should include, besides statistics, the archives of clinical records and the office of admissions and discharges. The monthly publications issued during the last year, which should cover at least up to three months before the month of the evaluation, should be requested. The chief of the statistics department and the chiefs of the principal services should be questioned on the date of the last meeting held for the purpose of discussing the published information and on the periodicity with which these meetings occur; they should be held at least every three months.

19. Hospital Governing Body

It includes the authorities, committees individuals or groups, that set the policies of the institution and control their implementation, as applicable.

Level 1: The establishment is headed by a director. The director is present at least six hours on workdays and manages the programming of activities.

The registration of signatures, in the case that the director does this, should be verified and several unranked staff members should be questioned about the presence of the director in the establishment, as well as his active participation in daily decision-making.
Level 2: The director has had specific training in health services administration. The institution has a Director (Chief Executive Officer), a Clinical Director (M.D.) and a Chief Administrative. The principal decisions are communicated in writing.

There is a Manual of Operational procedures and standards. The hospital has an annual budget and a continuous monitoring of expenses. There is an annual budget balance.

It should be verified in the office of Personnel that there is documentation attesting to the training of persons as administrative specialists. The budget for the last two fiscal years should be analyzed and budgetary execution compared. An evaluation of the balance sheet for the last fiscal year should be undertaken. The memoranda and communication issued by the medical and administrative management should be requested. It should be verified that periodic meetings of heads of departments and/or services have been held.

Level 3: The institution also has a medical/technical committee’s and a technical/administrative council. As an important element of advisory assistance to the director/clinical director and chief administrative officer, audited annual financial statements should be prepared by a reputable company or an authorized public agency.

It should be confirmed that periodic meetings of the technical, medical, and administrative councils are held (see proceedings). The financial statements from the last two fiscal years should be evaluated. Confirmation should be obtained of the audit conducted by a public accounting firm.

Level 4: The institution has a governing body (board of trustees, as applicable) which is the highest authority for the hospital and is responsible for formulating and establishing general policies; defining and approving the institution’s operational, administrative, and financial plans; verifying compliance and following-up the results of their execution. In addition, it is charged with setting priorities, approving the programs for services, and other functions to be defined in accordance with the nature of the institution (public, private, governmental, non-governmental, academic, etc.). There should be a general executive division and an internal auditing service under the board of directors. Annual financial statements should be prepared and an annual report should be published together with an auditor’s report.

It should be confirmed that meetings of the board of directors are held in accordance with the by-laws of the institution. There should be verification of the follow-up and execution by the operational sector of the resolutions of the board of directors. Internal audit reports should be analyzed. The annual report should be evaluated and observations made by external auditors on the annual financial statements for the last two fiscal years should be studied. The concept of depreciation of physical and operational infrastructure should be analyzed in the annual balance sheet.

20. Administration

Level 1: There is a trained individual responsible for the administration. There is a record of the certifications of the professional personnel. It has updated a manual of administrative procedures, (including operational routines, procedures and standards). There is a personnel office with files on all staff members that include certifications of training.

The establishment has at least one trained person that is responsible for:

- The acquisition, distribution, and control of the supplies and durable material resources.
- The records, liquidation of property, and control of the human resources.
• The administration of the financial resources, billing and payments to providers, and general budgetary control.

At least the professional personnel have their professional certifications recorded by that administration, which is evidenced in a review of the files of the professionals that are listed on the signs, especially those on duty. The administrative procedures and the routine actions are collected in a manual that records the main steps in each circuit. That compendium should contain at least the procedures related to the functions mentioned above.

There are files in the office designated for this purpose on all professional and nonprofessional personnel, in which are filed the certifications of training courses taken before hiring or during service. A representative random sample of files equal to 10% of the number of employees but not to exceed 40 files from different services and hierarchical levels should be selected, based on the list of regular staff, and the respective files studied.

Level 2: The individual responsible for the administrative area should be a professional. There should be an administrative and financial structure with all the necessary services for an effective management.

21. Occupational Safety and Health

Level 1: A health card for each employee should be available. There is a program for health safety of the personnel in accordance with the laws in force in the country. Intervention is made for care in cases of occupational accidents and necessary equipments should be available.

Fulfillment of this requirement should be verified in a sample of the files of 40 employees from different sectors and departments. In the different dressing rooms for the personnel, the availability of showers with hot and cold water should be verified. The chief of personnel should be questioned on the procedure through which occupational accidents are reported and treated; the existence in particular of an insurance contract to cover this should be verified. The personnel that reported accidents in the last six months should be questioned on the satisfaction with the care received. Staff members working with radiation should be monitored with personal dosimeters.

Level 2: There is a manual of procedures available in which material pertinent to the risks defined in the standards of the country is described.

In the nursing offices and physicians’ conference room and on bulletin boards, instructions should be posted concerning the risks of contact with the diseases mentioned and the precautions that should be adopted.

Level 3: The personnel is classified by risk group and, for each group, provision is made for the corresponding preventive programs. Clothing is provided for the personnel, along with its decontamination and laundering and the provision of bio-safety materials.

The entire staff is classified by risk group, according to their specific tasks and the degree of exposure. On the basis of this profile of risks preventive programs are prepared for electrical accidents, explosions, hepatitis B, tuberculosis, and other infectious pathologies. The head of departments should be questioned on the content of these preventive programs and those who are responsible for their implementation.

Both the provision of work clothes and uniforms for the personnel and their decontamination and laundering are the responsibility of the establishment through its own or a contracted service. The head of
departments should be questioned with respect to this, as should different employees that utilize work clothes or uniforms; there should be verification in particular that the replacement of soiled clothes occurs on a timely basis.

22. General Safety

   Level 1: It has emergency exits that are accessible and clearly marked and an evacuation plan, with training of the staff. It has a system for prevention and extinguishing of fires.

   In the company of the maintenance staff all the emergency exits should be visited, verifying that they are clearly marked and that, in the places that the public traverses, there are visible arrows that point toward the emergency exits. It is recommended that the doors open to the outside. The staff has received specific instruction on the system for evacuating the installations in case of a general alarm; there are also instructions exhibited in a visible place on how to proceed in these cases.

   Level 2: It has a program for disaster situations in accordance with the risk, approved by the appropriate authority.

   In accordance with the risks in each location preparation should be made for other catastrophes (such as earthquakes and floods). The programs for emergencies and catastrophes should be approved by the fire departments or civil defense or other competent authorities.

   Level 3: It has security and maintenance personnel on duty 24 hours a day.

   There should be verification in the office of personnel of the staff assigned, the distribution of schedules, and the duty rotations assigned. If the service is contracted, the terms of the contract should be reviewed and it should be ascertained whether it provides adequate coverage 24 hours a day.

   Level 4: It has a general alarm device and is integrated into the civil defense program.

   Through some acoustic or luminous mechanism the existence of a general alarm can be perceived from any place in the establishment. The pamphlets and technical specifications of the installed device should be requested and there should be verification that the device functions. The general alarm mechanism should be integrated into the civil defense program of the local community, as much for attention to the damage to the establishment as for the reception of the victims of the disaster.

23. Quality Improvement of Patient Care

   Level 1: It has activities that are organized in such a manner as to ensure the quality of medical care.

   The responsible parties should be asked as to the frequency, nature, and organization of evaluation sessions or meetings. The list of cases scheduled for discussion at the next meeting should be examined, as should the current selection of topics to be addressed during the following three months and the respective speakers. The health team should be asked concerning their participation in and impression of these evaluation sessions and whether they are carried out with multi-disciplinary criteria.

   Level 2: It carries out activities intended to evaluate the quality of care. The quality of professional performance within the establishment is ensured by:

* Periodic updating of the curriculum vitae and the recording of certificates of specialized training.
• Entry by selection on the basis of background.

Background checks should cover both professionals who are regular staff members and those who work in the hospital on an occasional basis and should be applicable to all health professionals. There should be verification in the office of personnel of files of a representative random sample of 10% the number of professionals, but not exceeding 40 professionals. The files should contain professional background information up to the preceding year, as well as copies of the respective certificates of specialized training for the activity that the professional performs.

Level 3: It has committees on quality assurance, infections, drugs, and other matters. Surveys are conducted to evaluate satisfaction of users and continuous cycle of improvement.

Such committees should be interdisciplinary and should include the participation of various services. They should have defined objectives and an annual program of activities, and they should record the work that is undertaken in proceedings or reports. Their recommendations should go directly to the management of the hospital and all decisions arising out of those recommendations should be communicated to all the services. The responsible parties should be asked with regard to the surveys carried out, their objectives, the questions asked, and the manner in which the sample was selected. The report of results and analysis of the latest survey should be requested and examined.

Level 4: It has a hospital epidemiology service and outreach approach to the community health problems, with specialized professionals and a research program aimed at quality improvement.

Building documentation

24. Plans

Level 1: It possesses updated plans in accordance with the building site and structure. If there is a radiology service the plans must be approved by the appropriate authority.

Level 2: It has updated plans for the installation of water, gas, electricity, and sewers.

Explanation for Levels 1 and 2: Updated plans are those that correspond faithfully to the actual status of the building structure at the time of the evaluation. These should be available at the establishment as required by the surveyor.

Level 3: It possesses plans of the existing services and installations, approved by the appropriate authority.

The corresponding approval should appear in the respective plans or in certificates on official letterhead.

Level 4: It possesses a dynamic, master architectural plan for construction under way or to be carried out.

The master plan should be available in the establishment as required by the surveyor; it should be written and clearly specify the purposes along with the means to achieve them. There should be verification especially of the degree of knowledge of the plan possessed by the director and the chiefs of the services.
Functional physical structure

25. Access

For all the levels one should observe the safety conditions and the protection from the weather provided to the patients that arrive at the institution in an ambulance or other vehicle.

Level 1: It possesses facilities where transported patients can enter and leave vehicles under safe conditions and with adequate protection, with appropriate physical barriers. The ambulatory services should have access suitable and safe for disabled.

Transported patients should not enter or leave vehicles on roads with high levels of vehicular traffic. When this does occur, the walkway should have a sheltered area for vehicular parking for protection over the walkway.

Level 2: It possesses differentiated entrances for vehicles and pedestrians.

Outpatients access the building by an entry different from that, which is designated as the entrance for transported patients.

Level 3: It possesses an exclusive vehicular entrance for the emergency service, with adequate signs.

The area for the parking and maneuvering of service or supply vehicles and those of the public and/or the staff should not overlap that for vehicles that arrive at the access area for the emergency service.

Level 4: It has personnel exclusively for the control of the entrances and for directing the public 24 hours a day.

All the entrances designated for use by the public 24 hours a day have personnel duly trained to direct the traffic properly. These personnel do not carry out any other type of work during the period it is assigned to that function. There should be verification in the personnel office of the scheduling of tours of duty to cover this function and of the presence of personnel in the designated accesses nights and holidays.

26. Circulation

Level 1: It has a division of areas as follows: general, technical, semi-restricted, and restricted. There are easily understood signs in the passageways (in all the areas).

There should be verification that the signs permit users entering for the first time to access the sectors experiencing the greatest use (emergency rooms, consulting rooms, services for diagnosis and treatment, baths, etc.) without needing to ask.

Level 2: Adequate circulatory independence is maintained between the public and technical areas in the services that care for patients.

There should be verification that the areas dedicated to the care of patients in critical condition are found in areas with general technical and/or specific technical circulation, with selective control of access. There should be special verification that there is no intermixing of general traffic in the intensive care and surgical areas.

Level 3: It provides for facility of movement in all the areas for patients.
There should be verification that at all levels stretchers and wheelchairs can circulate and that there are railings on all stairs and in the baths for the public.

Level 4: There is circulatory independence between technical and public areas in the entire establishment.

There should be verification of the circulatory differentiation in all its categories through a tour through the entire establishment, and especially of the total independence of the general traffic from the rest of the categories.

**Installations**

27. **Electrical System**

Level 1: It meets standards of safety for patients, personnel, and the public. It possesses alternative systems of illumination and power supply, if applicable, for the critical areas.

The control of the electrical system should be distributed with a central board and sectoral boards or boards on the floors. There should be verification of the existence of emergency illumination of the critical areas and the emergency. The operation of such alternative systems should be verified at the time of inspection.

Level 2: It possesses alternative systems of energy generation for the critical areas.

The electric circuits of the critical areas and the emergency exits should have an alternative source of energy generation (electricity-generating group) whose adequate operation should be verified during the evaluation.

Level 3: It has systems to ensure uninterrupted lighting and generation of energy for the normal operation of the health establishment.

There should be verification of the existence of a central electrical generator; along with specialized technical personnel, and that its mechanisms work fully at the time of the evaluation. That device should be connected to the central board and will have a central key for transferring the energy source.

28. **Control of Excreta, Wastes, Water Potability, and Radioactive Wastes**

Level 1: They conform to municipal, provincial, national and/or WHO standards. It has drinking water service and a system for the elimination of excreta. It has a special system for safe waste disposal.

Inquiry should be made into the background of the standards to which these services adhere, whether they are filed in the establishment or were required previously by the local inspection authority. The water tanks should have permanent covers. Both the drinking water and the final disposal of the wastewater are provided by a public network; when the latter does not provide drinking water, the quantity of stored potable water should be verified. Through questioning of the maintenance staff, the existence of a blind household well and of water well with pump should be ruled out. Wastes are disposed through a special “dirty” discharge point, equipped with resistant plastic bags within rigid-walled containers to avoid puncturing of the personnel that handle them.

Level 2: There is preventive maintenance of all sanitary installations. The high-risk solid wastes are identified and receive differentiated treatment.
At least every three months the maintenance staff verifies the correct operation of all faucets, toilets, water heating systems (of various types), and discharge points for inspection of waste water. Contaminated solid wastes posing a high risk—except food—are stored in resistant bags that are labeled or of a differentiated color and handled with gloves; they are not mixed with the common solid wastes; there should be verification of compliance with this requirement with service personnel. Safety measures should followed in dealing with contaminated sharps.

Level 3: It has its own specialized technical personnel or a service contract for this purpose. It has a specific area for storage and disposal of solid wastes and these are collected twice a day.

The maintenance service for these areas is the responsibility of specialized technical personnel (sanitary engineers, labor safety engineers, or the equivalent), who are either employees or are supplied through contract with a specialized company. There is a specific site exclusively for storage of the solid wastes that are removed through a door designated for this purpose only. Twice a day the wastes are collected and are deposited at this site, which is washed once a day, after the final collection by the public service.

29. Patient Comfort

Level 1: All rooms meet standards for comfort in accordance with the needs in the Region.

In the daytime they will have natural lighting. In the geographical areas where the average winter temperature exceeds 13 degrees Centigrade, heating will be optional. The rooms should have heating through devices that do not consume oxygen from the environment and discharge combustion gases outside (central heating, gas heater with controlled flame, air conditioning, quartz electric heater set in the wall).

Level 2: All the bathrooms have hot and cold water available 24 hours a day.

The bathrooms are supplied with hot and cold water, at least in the washroom and the shower. A sample of 10 patients from different sectors should be questioned about the existence of hot water at all hours. This requirement depends on the climatological characteristics of the region.

Level 3: There is a private bath in all rooms, in accordance with the requirements established by the office of sanitary engineering in the Region.

Every room, regardless of the number of beds, has a bath to which there is access through an interior door of the room.
FACULTATIVE SPECIAL STANDARDS

30. Critical Care

Included in this category are the services designated for the care of patients at risk of imminent death.

Level 1: It has an intensive care unit (ICU) provided with the essential technological resources and has its own personnel continuously.

It is a service for patients for whom total or partial recovery is possible and who require constant, continuous medical and nursing care for their survival. It should have medical and nursing staff, assigned with exclusiveness in such a way that coverage is of the same intensity 24 hours a day. It should have the following:

- Stock of drugs and disposable materials.
- Oscilloscope monitors.
- Synchronizer-defibrillator.
- Transitory internal pacemaker.
- Cart for endotracheal intubation.
- Electrocardiographs.
- Volumetric mechanical respirator.
- Equipment for trachidial or thoracic puncture.
- Equipment for nasogastric, vesical, or venous catheterization.
- Laboratory for clinical analysis, hemotherapy and radiology services, on call 24 hours a day.
- Oxygen; central compressed air and aspiration.
- Alternative source of electric power.
- Central nursing monitoring station.

Note: The facultative or noncompulsory standards apply both to diagnostic and treatment services that require investment in equipment that is technologically highly complex (intensive care, neonatology, nuclear medicine, radiation therapy, and rehabilitation) and to support services whose presence contributes substantially to the improvement of the quality of the medical care, although frequently not foreseen in the hospital organizations that are the object of this manual. In the case of the services mentioned in the first group, a set of requirements with respect to their equipment are established; these are only to serve as guidelines and are subject to the specific standards in effect in the particular EMR country. When services are not supplied by the establishment, but have been contracted, the institution should assume responsibility for the fulfillment of these standards on the party of those services.
• Availability of central or departmental sterilization facility

The individual responsible for the unit makes a circuit of the beds with the physician on duty in the unit and maintains daily exchange with the ward physicians. The possible participants in those interchanges should be questioned.

Level 2: It has a completely equipped ICU, supplemented with a unit for intermediate care.

The intermediate care unit is designated for patients that require constant, continuing nursing care that cannot be provided under general hospitalization. It should have equipment similar to the ICU treated in Level 1 above. The nursing personnel should be exclusive but the medical personnel can be ICU or ward physicians that follow the intermediate care unit patients; this will only be required in the establishments that have completely provisioned intensive care. The ICU provided with complete technological resources should have the following:

• Equipment similar to that mentioned as the basic resources for the ICU, concentrated so that it is available for each patient at all times (see Annex A).

• Qualified trained medical and nursing personnel, assigned with exclusiveness, 24 hours a day.

• Laboratory for clinical analysis, blood bank, and radiology service, with personnel available and on duty 24 hours a day.

The medical staff of both units meets in a forum at least once per month and the physicians responsible for the sector participate weekly in the ward forums for the purpose of follow-up among different levels of intensity of care. During the previous year the nurses in the unit have received specific training courses.

Annex A: Equipment, instruments, and minimum supplies for one completely provisioned ICU:

• Stock of drugs and disposable materials that would cover the needs of care for 24 hours.

• Synchronized-defibrillator: one for every two beds.

• External transitory pacemaker available with two cable catheters: one for every four beds.

• Resuscitation cart with equipment for complete endotracheal intubation and drugs necessary for treating cardiopulmonary arrest: one for every bed.

• Mechanical respirator with volumetric positive pressure: one for every four beds.

• Complete equipment for nasogastric, vesical, and venous catheterization.

• Complete equipment for rachidial, thoracic, and abdominal puncture.

• Equipment for peritoneal dialysis.

• Portable suction for drainage: one for each bed.

• Oxygen, compressed air, and central aspiration with individual outlets for every bed.
31. **Neonatology**

*Included in this category are the services and installations designated for the care of the normal newborn (NN) and pathological newborn (PN), as well as the neonatal intensive care unit (NICU) for newborn with serious clinical and surgical syndromes.*

**Level 1:** It has an exclusive site designated for the medical care of the newborn.

The site should be suited to receive the NN, in a location next to the delivery room. It should be air-conditioned at the proper temperature; it is provided with hot water 24 hours a day and the newborn can be bathed if necessary. It has a laryngoscope, balance, oxygen, aspirator, and compressed air. It has a portable incubator for transferring the child to an appropriate environment, if there are clinical complications. The physicians that receive the NN form part of the pediatrics service of the hospital and are linked to the NICU through forums and case follow-ups. The possible speakers at these exchanges should be asked.

**Level 2:** It has a sector designated for the care of the PN, clearly differentiated from the NN, that can resolve the principal clinical syndromes of the newborn.

The different environments of the area for care of the PN constitute a differentiated functional unit, located in an area of restricted circulation. It can receive children born in the same or transfers from nearby facility. The medical and nursing personnel are assigned exclusively to this sector; there should be verification in the office of personnel of the scheduling of the staff 24 hours a day seven days a week. It possesses complete equipment for: resuscitation, exsanguine transfusion, pneumothorax drainage, and canalization of the umbilical artery. It has equipment for light therapy, neonatal mechanical respirators, transcutaneous oxygen monitors, an oximeter, and continuous positive pressure. The unite should have qualified neonatologist responsible for the service makes rounds daily with the physician of the service on duty. The nursing personnel have received specific courses of instruction during the last year, presented by the physicians in the service.

**Level 3:** It has a NICU, differentiated and organized semi-autonomously, that acts as a referral service for the health facilities of the area.

The NICU constitutes an assistance complex with medical and nursing personnel and appropriate support and its own administration of supplies and equipment. It has a reception area, a waiting room, a nursing station, sites for the incubators, isolation areas, rest area for physicians, rest area for the mothers, storage area for supplies and equipment, etc. The NICU should have the following:

- Equipment available according to Annex A.
- Provision of highly trained medical and nursing personnel, assigned with exclusiveness 24 hours a day.
- A laboratory for clinical analysis, a blood bank, and a radiology service available 24 hours a day with personnel on duty within the hospital.
- Equipment for life saving emergency and postoperative intervention.
The medical staff meets in a weekly forum and the individual responsible for the NICU makes rounds daily. The nursing personnel receive classes of instruction and training on a regular basis at least once a month.

Annex A: Minimum equipment for a NICU.

- Stock of suitable drugs and disposable material for 24 hours.
- Conventional incubators.
- Transcutaneous oxygen monitor: one for every five beds.
- Pulse oximeter: one for every five beds.
- Equipment for resuscitation, exsanguinotransfusion, central venous pressure, canalization of the umbilical artery, pneumothorax drainage: two of each in the area.
- Oscillometric tensiometer: one for every five incubators.
- Electrocardiograph with pediatric electrodes: one in the area.
- Apnea monitor: one for every three incubators.
- Optic fiber transilluminator: one in the area.
- Oscilloscope-defibrillator: one in the area.
- Neonatal respirator: one for every five beds.
- Equipment for continuous positive pressure: one for every four incubators.
- Continuous perfusion pumps: one for every three incubators.
- Pump for negative aspiration: one for every three respirators.
- Gas mixer: one for every six incubators.
- Humidifying heaters: one for every three incubators.

32. Hemotherapy

Level 1: It has an exclusive site designated for this purpose that meets the standards for hemotherapy service. The service is under the direction of a physician specialized in hemotherapy.

*The hemotherapy service is the technical administrative entity responsible for transfusions, with the elements provided by the blood bank, including preliminary immunohematologic study. The hemotherapy service is responsible for the blood that it provides so that it should periodically verify that the components that it receives from the blood bank meet the standards in effect for communicable disease prevention. Those standards dictate that in every transfusion unit the following serologic tests should be carried out:*
• Syphilis (VDRL).
• Brucellosis (Huddleson’s test).
• Hepatitis B and C antigens.
• Detection of HIV antibodies.

There should be verification in the office of personnel of the history of specialized training of the responsible physician. The responsible individual personally supervises the units received from the blood bank; this should be confirmed by questioning its personnel and observing the signature on the receipts for the last month. The bags are stored in a refrigerator with the sections labeled by blood group. The service extracts blood to supply the bank.

Level 2: It has technical or medical hemotherapeutic personnel on duty 24 hours a day.

There should be verification in the office of personnel of the list of technical or medical personnel assigned to the service, with their hours and the scheduling of their rotation. Both the technical personnel and the physician have some specific training. There should be inquiry into the frequency with which they meet with the individual responsible for the service in order to address operational problems and whether they have met within the last three months.

Level 3: It has a blood bank that has all the following characteristics:

• It is directed by a specialized professional.
• It has a register of blood donors.
• It has standardized its procedures for processing and storing blood.
• It is a reference center for other establishments.
• Makes periodical evaluations to adverse reactions.

The blood bank is the technical administrative entity responsible for the following functions:

• Study, clinical examination, selection, classification of donors, and extraction of blood.
• Classification and control of the blood and its components.
• Division of whole blood in order to separate components.
• Conservation of the components for their provision on demand.
• Provision of raw materials to the blood derivative plants.

It should be certified by the corresponding health authority and the certificate should be exhibited in a visible place. There should be verification in the office of personnel that the individual responsible has been awarded the professional degree of hemotherapy specialist. There should be observation of the register of blood donors as well as the clinical lists in which the health data for their admission as donors
are recorded, in accordance with legislation in effect. The manual of procedures for the service should be observed to verify that it is accessible and the personnel should be questioned with regard to the instruction received with respect to those procedures. At least every three months meetings are held to address operational matters. The responsible individual should be asked for the list of establishments that are supplied by the bank at the same time that they provide donated blood: the file of receipts from the establishments to which blood was shipped during the last three months should be checked.

33. Nuclear Medicine

National (or international) standards for radioactive protection should be followed. There should be compliance with national standards for radioactive protection.

Level 1: It has the infrastructure necessary for the various in vivo diagnostic applications of radioisotopes, in the form of radioactive tracers, and those therapeutic applications derived from them.

It is under the direction of a medical professional, a specialist in nuclear medicine. The specialists are certified by the competent jurisdictional authority, and the respective certificates should be exhibited in a visible place. It has a linear scintillograph, a properly calibrated activity meter, and a manual well-type detector. The radioactive tracers should be kept in a storage area that meets the standards presented by the competent authority. Every piece of equipment for measurement should be in an exclusive site.

Level 2: Has a special unit of Nuclear Medicine.

The responsible individual is assisted by one or more technicians that have specific training in the management of the equipment and the handling of the radioactive material, acquired either by special courses or by in-service instruction. It may or may not have a linear scintillograph. It has a detector for measurements in vivo and the gamma chamber should have a computer processor of images and measurements. Every piece of measuring equipment should be in an exclusive site.

Level 3: It has more than one professional specialist in nuclear medicine and their functions include health care, teaching, and research.

The responsible individual is assisted by one or more professional chemists, biochemists, physicists, or pharmacists, authorized to handle radioisotopes. It has a portable monitor and it may or may not have a whole-body scintillograph. It has a room for radioactive decontamination; it has facilities for the processing of photosensitive films. It develops undergraduate and graduate teaching activities as well as programs for applied research, based on activities of the service. It may have photon-emission or positron-emission computerized tomography.

34. Radiation Therapy

The service should comply with the standards, dictated by the competent authorities in every jurisdiction, with regard to installations for health radiation physics and nuclear energy. There are two types of services: teletherapy and brachytherapy. Brachytherapy by itself does not constitute a service of radiation therapy. It can be included at any of the three levels without implying changes in the level of the requirements; if this technique is utilized, the corresponding authorizations must first be obtained. Included under the term brachytherapy are treatments with infused or implanted radioisotopes, such as the placement of needles or tubes of radium 226, cesium 132 (cancer of the uterine cervix), therapeutic doses of iodine 131 (thyroid cancer), intracavitatory solutions (neoplastic effusions), or interstitial implants of iridium 192 (breast cancer) or others.
Level 1: It has equipment for cobalt therapy with or without equipment for contact radiation therapy that comply with radiation protection programme. It should be under the direction of a specialized physician and have therapeutic protocols for each pathology.

It should be under the direction of a physician specialized in radiation therapy, who should be certified by the corresponding authority for control of radiation; the certificates should be exhibited in visible place. It complies with the legal provisions for protection of the entire staff from exposure to radiation. The corresponding documentation should be observed. In the personnel office the certificate of the radiotherapy specialist should be verified. The compendium of therapeutic protocols should be observed and the specialist should be questioned with respect to their effective application. It should have specialized technicians and access to the advice of a physicist/physician for calibration of the equipment, clinical dosimetry, and treatment planning.

Level 2: It has a linear accelerator of up to 5 MeV, without the capacity for the utilization of electrons. It has a simulator/localizer. It is involved in collaborative groups for treatment of cancer.

The linear accelerator is a device that produces X-rays by the impact of a beam of previously accelerated electrons on a special anode. The high-performance apparatus permits the therapeutic utilization of both the electron beam and the X-rays. The simulator/localizer is a low-power radiological device with the same geometry as that for radiation therapy that permits—by means of radiological plates with or without the assistance of an image intensifier—location of the volumes to be irradiated and simulation of the treatment fields, making it possible to delimit with precision the field to be irradiated. The professional or professionals in the service participate in collaborative groups providing a comprehensive approach to cancer involving oncologist, chemotherapists, surgeons, and clinicians, belonging either to the same institution or to other establishments. The equipment should be calibrated by the physicist/physician.

Level 3: It has a linear accelerator of more than 5 MeV that can emit X-rays or electrons, at the discretion of the therapist. It allows computed dosimetry of the treatments.

Computed dosimetry makes it possible to calculate exactly the radiation dose to deliver; through the calculation of the effective beam, penumbra areas, and isodose curves, it reduces the risk of irradiation of healthy tissues; this information is presented in a graph and is the basis of the simulator-locator.

35. Rehabilitation

Level 1: It has specialized personnel that provide treatments for primary rehabilitation in general hospitalization and/or intensive therapy, as required by the medical staff of each service.

The specialized personnel consist of physiotherapy or physical therapists whose certification should be confirmed in the office of personnel, who may or may not be on the staff. They provide treatments of respiratory physiotherapy and neurological physiotherapy in acute cases.

Level 2: It has a specialized service that treats outpatient’s and has the necessary minimum installations. The service is under the supervision of a qualified person in rehabilitation.

The service is also made up of speech and hearing specialists and occupational therapists. The installations consist of, at the very least: a consulting room, room for occupational therapy with sufficient equipment for practicing the activities of daily life and a gymnasium for cardiovascular, neurological, and orthopedic rehabilitation. The equipment in the gymnasium should include parallel bars, a wall mirror, a ramp and stairs, a stationary bicycle, mats and pulleys; it should also have a Bier oven, short wave, infrared, and ultraviolet rays in the physiotherapy section.
Level 3: It has a comprehensive rehabilitation service, equipped to develop the greatest part of the treatments of the specialty, on an outpatient basis and for inpatients. It is under the direction of a physician specialized in rehabilitation, with support from other specialties. There is a mechanism for follow-up of the treated patients.

A comprehensive service should provide the following treatments:

- physiotherapy: short wave, Bier oven, ultrasound, infrared, and ultraviolet rays, electrotherapy, iontophoresis, cervical traction
- kinesitherapy: massages, mobilization, muscular reeducation, therapeutic exercises, respiratory and cardiac rehabilitation
- treatment of: amputations, malformations, congenital and acquired neuropathies

It should be under the direction of a medical physiotherapist or someone in a related specialty, with other supporting specialists (neurologist, traumatologist, otorhinolaryngologist, etc.) and auxiliary professionals (kinesiologists, speech and hearing specialists, occupational therapists, psychotherapists). The professionals in the service maintain an exchange with the rest of the services and participate in the forums. They enter their therapeutic programs in the clinical records. After the conclusion of the treatment, the patients are given appointments at regular intervals that are established for each pathology so that the evolution of their condition can be evaluated. The individual responsible for that follow-up should be questioned about the mechanism by which it is carried out and its implementation should be evaluated.

36. Promotive Health Services

Level 1: The care provided by the hospital includes activities related to risk reduction. These include but are not limited to Smoking Cessation, Obesity Reduction, Premarital Examination and Genetic Counseling.

The hospital has active smoking cessation clinic, obesity reduction clinic, premarital examination and genetic counseling activities.

Level 3: The hospital has an active role in Community Development

The hospital are involved in active programs concerned with community development like health education program (inside and/or outside the hospital), community based medical research and Healthy City program.

37. Social Service

Level 1: It has at least one social service professional and an area adapted for the development of that person’s work.

There should be verification in the office of personnel of the record of training in a recognized public or private institution. Verify the existence of a site fulfilling the privacy requirements and time available for interviews and meetings, for purposes of discretion and intimacy.

Level 2: There are written standards and policies and procedures that should be reviewed periodically.
There should be a review of the existing standards, their availability, the date of the last updating, and the knowledge that the members of the service have about them. The files of the socioeconomic reports on the patients and the record of the tasks that are carried out should be observed.

Level 3: The service is integrated with other health care professionals

There should be verification of their participation in forums and meetings and of the records of their activities in 10 clinical records provided by the appropriate service. No fewer than two individuals responsible for services should be questioned on the frequency with which the social service intervenes.

Level 4: It develops extramural activities, such as making house calls and community contacts, fostering institutional relations, and identifying groups at risk.

There should be verification in the records of the service of: a file on community resources, reports of house calls, a file of notes and reports, etc. The existence of social statistics on the area of influence of the establishment, transfers to other institutions, contacts with organizations for the public good for the purpose of obtaining benefits for patients, and related matters should be observed.

38. Library

Level 1: There are updated publications concerning the four basic and emergency care in the form of textbook or manuals.

It has treatises or manuals, published in the native language not over five years previously, that cover at least: clinical medicine, surgery, gynecology, obstetrics, pediatrics, and emergencies. The texts are available in the office of the management or in a physicians’ rest room and can be consulted only within the establishment.

Level 2: It is under the direction of personnel that control entry and egress. The incorporation of material is not programmed. It has subscriptions to some scientific journals. It has texts on others specialties.

The personnel assigned are administrative and carry out other duties, in addition to those specifically for the library. The incorporation of bibliographic material is done at the request of the medical staff or as a result of unevaluated donations (all the material that it is donated is incorporated). There are subscriptions to at least two scientific journals. There are publication about hospital and health system administration and others health services

Level 3: It has exclusive personnel. There is a program for incorporation of bibliographic material. It functions at least six hours per day and has international indexes.

The personnel is assigned exclusively to the library. The program defines the publications to be incorporated and those that should be dropped. The international indexes are current at least up to the previous year. Through an annual mechanism of consultation with the heads of the services, the publications that need to be acquired are specified each year and, on the basis of these requests, the bibliographic budget for the fiscal year is prepared.

Level 4: There is a committee of professionals that prepares the annual bibliographic program. The individual who is in charge of the library and has specialized library training is a member. The library has access to international bibliographic data banks and electronic database. It is desirable that it issues its own publication.
The library committee prepares an annual program, for the purpose of:

- Incorporating bibliographic material.
- Reporting to the professional corps on the availability of materials.
- Dropping the obsolete or unserviceable material.
- Preparing the budget of the section.

There is a photocopier available for the library during its hours of operation. It has a computer with programs for filing and a connection with international databases. The library’s publication will be considered relevant when it is published on a regular schedule, is exchangeable with others that are similar, and reflects the health care and research activities of the establishment.
Appendix

EXAMPLES OF INDICATORS OF THE QUALITY OF MEDICAL CARE, SPECIFIED BY SERVICE OR SPECIALTY, TO BE REVIEWED AND ADAPTED TO THE LOCAL CONDITIONS OF EACH HOSPITAL

Selected by Humberto M. Novaes, M.D., Ph.D, President, INTECH, Inc, Washington, D.C.

INDICATORS IN TECHNICAL OR ADMINISTRATIVE AREAS

Admissions

• Promptness of admission procedures.
• Accuracy in data collection (for example: personal data, social security, address, etc.)
• Accuracy of medical records and in the account number assigned in private hospitals.
• Fulfillment of the requirement of obtaining the patient’s consent.
• Patient complaints.

Medical Records

• Promptness in the collection and reporting of data.
• Lost/misplaced records.
• Accuracy of coding.
• Promptness and accuracy of transcription services.
• Satisfaction of the physician.
• Compliance with the procedures for handling requests for confidential information.
• Promptness in filling requests for old records.
• Accuracy in census reports.
• Percentage of qualitative evaluations of clinical histories.

Outpatient Care

• Capacity for patient surveillance with monitors.
• Promptness and accuracy of documentation.
• Patient incidents.
• Accuracy of the patient appointment system.
• Compliance with criteria for discharge.
• Compliance with infection control procedures.
• Patient complaints.
• Physician complaints.
• Patient waiting time of more than “x” hours.
• Admission of patients for observation during the night.
• Number of first consultations versus emergency consultations.

**Emergency**

• Precision in the follow-up of cases with abnormal test results.
• Patient satisfaction.
• Compliance with documentation requirements.
• Relevance of instructions to the patient upon discharge.
• Patient incidents, other than errors in medications.
• Mortality in the first 24 hours.
• Compliance with infection control procedures and safety measures.
• Relevance of patient management.
• Length of time between admission and evaluation by the nurse.
• Physician satisfaction with the service facilities.
• Lesions from contaminated needles.
• Compliance with protocols for patient management.
• Unsuccessful attempts at cardiopulmonary resuscitation.
• Patients that wait more than “x” hours.
• Re-admissions due to inadequate/unnecessary treatment.
• Claims due to professional incompetence.
Other Indicators for Outpatients and Emergency Patients

- Inability to locate medical record.
- Staffing.
- Recording of date, hour, and signature for all admissions.
- History of allergies not documented.
- Clinical-administrative event not documented.
- Incident occurring in the clinic.
- Complications of phlebotomy.
- Complications of treatment.
- Death of a patient within less than 24 hours after the visit to the clinic.
- Diagnosis at variance with electrocardiogram, X-ray, or other test.
- Error or adverse reaction in the administration of drugs.
- Anaphylaxis.
- Transfer of emergency case to another facility.
- Adverse reaction or emergency in special area of operative care.
- Transfer and death to Emergency Room during first 4 hours after admission.
- X-ray interpretation in Emergency Room at variance with reading by the Radiology service.
- Failure to interview of patient with expressed suicidal manifestations.
- Lack of response to therapy.
- Hospitalization within 48 hours after visit to Emergency Room.
- Illegible handwriting.
- Inappropriate/inadequate documentation of immunization.
- Inappropriate handling (diagnosis/treatment) of patient with venereal disease.
- Inadequate follow-up or inappropriate referral.
- Inappropriate delay in seeing patient with acute disease/situation.
• List of problems too brief or incomplete.
• Error in endovenous medication.
• Failure to follow up on anomalous values in laboratory or x-ray results.
• Laboratory/radiology questions:
  • Incorrect data provided.
  • Requested test not performed.
  • Specimen lost or poorly labeled.
  • Incorrect study requested.
  • Inadequate preparation for procedure.
  • Physician/place not listed in request form.
• Prolonged delay in reporting of test results, with adverse effects.
• Laboratory/radiology support:
  • Laboratory/X-ray results not recorded.
  • Prolonged delay in reporting, with adversely effects for care of patient.
• Diagnostic procedure not performed.
• Diagnosis or specimen lost.
• Neonate under 6 weeks of age not evaluated by pediatricians.
• Consent for invasive procedure not obtained.
• Lack of documentation of instructions for the patient, or inadequate or incorrect documentation.
• Organ deterioration or failure:
  • Cardiopulmonary arrest prior to admission to Emergency Room; cardiopulmonary resuscitation successful.
  • Cardiopulmonary arrest occurred prior to admission to Emergency Room; cardiopulmonary resuscitation unsuccessful.
  • Cardiopulmonary arrest in Emergency Room; cardiopulmonary resuscitation successful.
  • Cardiopulmonary arrest in Emergency Room; cardiopulmonary resuscitation unsuccessful.
• Patient dead on arrival at hospital.
• Complaint of patient or family, Admitting Room.
• Complaint of patient or family, Emergency Room.
• Injury to patient during the diagnosis/treatment.
• Instructions given to patient in Emergency Room not available on chart.
• Departure of patient without being seen or against medical advice.
  Treatment denied.
• Discharge of patient without documentation of instructions.
• Patient stay in clinic or as outpatient longer than 4 hours.
• Patient stay in Emergency Room longer than four hours.
• Patient seen in Emergency Room with complications from outpatient care.
• Diagnosis by “process of elimination” after two visits to the clinic.
• Work-related injuries.
• Indication of or attempt at suicide.
• Failure to take statement in case of suspected sexual abuse.
• Failure to take statement or follow up in case of suspected spouse or child abuse.
• Delay of more than 60 minutes to see physician.
• Unplanned admission to clinic or outpatient center.
• Unplanned admission to hospital by patient seen in clinic less than 48 hours earlier.
• Unplanned readmission to clinic or outpatient center.
• Unplanned readmission for the same problem within less than 48 or 72 hours.
• Failure to record vital signs at every visit.
• Waiting time longer than 2 hours.
• Infected wound resulting from a procedure.
Nursing

- Accurate evaluation of patients.
- Compliance with requirements for documentation.
- Early recognition of symptoms that may alter the patient’s situation.
- Satisfaction of patient/physician.
- Errors in medication.
- Compliance with protocols for patient management.
- Patient incidents.
- Nurses’ interventions relevant to patient’s condition.
- Compliance with infection control procedures and safety measures.
- Punctuality in the administration of drugs.

Other Events in Nursing/Support Care

- Procedure or therapy canceled due to inadequate preparation of the patient.
- Appearance of bedsore or eschar.
- Nosocomial infection.
- Improper disposal of needles.
- Improper preparation or administration of intravenous drugs.
- Nursing report incomplete.
- Incorrect transcription of physician’s directions.
- Insufficient nursing staff to care for patient needs.
- Lack of documented evaluation by a graduate nurse < 24 hours.
- Lack of equipment or equipment in poor condition.
- Diagnostic procedure or test performance without authorization by physician.
- Excessive delay for specimen/result.
- Failure of graduate nurse to notify physician of important changes in patient’s condition.
• Programmed treatment or procedure not performed:

• Vital signs ordered more than every four times.

• Change of dressing.

• Laboratory test (for example, blood, urine).

• Fluid intake/output not recorded.

• Daily weight.

• Unplanned removal of an invasive tube.

• Use of restraint resulting in loss of circulation in a limb or other injury to patient.

• Injury to a visitor.

**Nursing Services in the Emergency Room**

• Cardiac vital signs taken at least every 15 minutes unless otherwise indicated.

• Physician’s orders not checked.

• Error in medication.

• Administrative nursing problem or event.

**Obstetrical Nursing**

• Delay in communicating complications to the physician.

• Inadequate monitoring of the delivery room.

• Inadequate monitoring of the patient.

• Birth in waiting room outside Delivery Room.

**Operating Room**

• Time elapsed between cases.

• Compliance with infection control procedures and safety measures.

• Patient incidents.

• Time elapsed between scheduled hour for a surgical procedure and actual time of the intervention.

• Misplacement of the results of preoperative tests at the time of a surgical intervention.
• Appropriate administration of drugs.
• Compliance with documentation requirements.
• Death in the operating room.
• Correlation between a single surgical team and infection of surgical incision.

**Postoperative Recovery Room**

• Compliance with criteria for patient discharge.
• Patient incidents.
• Compliance with documentation requirements.
• Compliance with infection control and safety procedures.
• Physician satisfaction.
• Errors in medication.
• Appropriate evaluation of patients.

**Social Services**

• Promptness in responding to requests for services.
• Appropriate evaluation of patients.
• Patient/physician satisfaction.
• Appropriateness of post-discharge arrangements.
• Compliance with documentation requirements.
• Measurement of goals.
• Complaints from family members.
• Complaints from referral sources.
• Delayed receipt of referrals.
• Delays in patient visits.
• Referrals inadequate/unnecessary.
• Referrals lost.
Other Indicators related to Social Work

- Failure to recognize a psychiatric disorder.
- Inadequate plan for patient discharge.
- Lack of plan for patient discharge.
- Repeated abuse of spouse or child.

Pharmacy

- Dispensing errors: transcription of prescription, interpretation of the prescription, dispensing (quantity and type of drug dispensed).
- Number of drugs that need to be repackaged (measures drug quality assurance up to the time of use).
- Written information provided to patient on drug therapy compliance and risks associated with the drug.
- Existence of a drug therapy profile and objective for its use with information provided about the existence of drug surveillance.
- Number of drugs in the Basic Table out of stock for 7 days (indicates availability of adequate supply to ensure therapy).
- Number of doses not administered to hospitalized patients and reason therefore (measures compliance with drug therapy).
- Medical prescription in stock per patient admitted (emphasizes drug administration as a part of health care).
- Number of prescriptions/number of prescriptions per patient (measures extent of polypharmacy).
- Number of drugs included in the Basic Table/number of drugs in Basic Table used by hospital (measures rational prescription practices).
- Use of nonproprietary name of drug in the prescription (indicates rational prescription practices).
- Existence of a Committee on Pharmacy and Treatment and availability of professionals to serve on it (indicates involvement of physician and nurse in the process of drug supply and rational use).

Some examples of Drugs; Potential Indicators and Indicators of Results

<table>
<thead>
<tr>
<th>Drug type</th>
<th>Adverse reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants</td>
<td>Loss of blood</td>
</tr>
<tr>
<td>Aminoglycosides</td>
<td>Renal deficiency</td>
</tr>
<tr>
<td>Penicillin</td>
<td>Allergic reaction</td>
</tr>
<tr>
<td>Cephalosporin</td>
<td>High costs</td>
</tr>
</tbody>
</table>
**Laboratory**

- Promptness in responding to requests.
- Test results doubtful.
- Adequate collection of specimens.
- Results of Gram staining vs. final reports from culture.
- Compliance with infection control and safety procedures.
- Venipuncture performed unnecessarily.
- Patient incidents.
- Compliance with standards for preparation of specimens for special tests.
- Promptness of reports.
- Waiting time for outpatients.
- Accuracy of reports on test results.
- Specimens lost.
- Patient/physician satisfaction.

**Radiology Service**

- Allergic/adverse reactions.
- Proportion of films damaged/repeated/rejected.
- Procedure adequately explained to patient.
- Waiting time for outpatients.
- Promptness in responding to requests.
- Promptness of reports.
- Films lost/misplaced.
- Compliance with infection control and safety procedures.
- Importance of patient’s return to repeat a procedure.
- Quality of X-rays taken in the operating room.
- Requests for versus tests performed.
- Compliance with documentation requirements.
- Periodic control of technical parameters relating to equipment.
- Control of radiation dosage.
- Competence of staff.
- Patient incidents.
- Patient/physician satisfaction.

**Other Laboratory Indicators, Radiology, Hemotherapy**

- Aspiration during upper gastrointestinal series.
- Failure to comply with radiation safety requirements.
- Cardiac or respiratory arrest.
- Reaction to contrast (requiring intervention).
- Units of blood destroyed.
- Emergency distribution of uncrossed blood.
- Evidence of thrombosis following a procedure.
- Excessive waiting time for hospitalized patients or outpatients.
- Extravasation of contrast.
- Failure to identify potentially dangerous specimens.
- Improper collection of sample (tube, anticoagulant, etc.).
- Hematoma at injection site requiring intervention.
- Improper labeling of specimen.
- Inadequate preparation of patient for procedure.
- Specimen presented inappropriate for procedure requested.
- Inaccurate interpretation of the results of the tests or the procedure.
- Inadequate examination prior to X-ray.
• Inadequate preparation of the large intestine for fluor/radiology studies.
• Inordinate waiting period for the result.
• Failure to comply with hospital policy on infectious diseases.
• Insufficient supply of reagents.
• Invalid patient results transmitted by laboratory.
• Failure to comply with first aid instructions.
• Myocardial infarct/cerebrovascular accident during a procedure or within 48 hours thereafter.
• Improper administration of radioisotopes.
• Film misfiled.
• Multiple examinations or vague history.
• Failure to perform laboratory tests requested.
• Patient injury or accident.
• Failure to comply with policy for patient treatment/support.
• Patient punctured more than twice for a blood test.
• Perforation during barium enema.
• Pneumothorax after invasive procedure.
• Portable film defective.
• Headache after myelogram (requiring intervention).
• Repetition of a procedure because of inadequate results.
• Action not taken on the basis of information reported.
• Seizure within less than 24 hours after a procedure.
• Transfusion of a single unit of blood.
• Failure to label tubes.
• Examination performed without authorization.
• Failure to report information that would have an adverse effect on patient care.
• Incorrect examination performed on a patient.

• Incorrect study ordered.

• X-ray results not found in the record.

**Nuclear Medicine Service**

• Compliance with quality control procedures.

• Promptness in responding to requests.

• Waiting time for outpatients.

• Patient incidents.

• Compliance with infection control and safety procedures.

• Quality of films to be used for diagnosis.

• Examinations repeated.

• Compliance with procedures for disposal of expired isotopes.

• Requests for versus tests performed.

• Promptness of reports.

• Patient/physician satisfaction.

**Electroencephalography Service**

• Promptness in responding to requests.

• Requests for versus tests performed.

• Patient incidents.

• Quality of electroencephalogram.

• Time required producing reports.

• Physician satisfaction with the services.

**Hemodialysis**

• Patient incidents.

• Compliance with protocols for patient management.
• Compliance with infection control and safety procedures.
• Compliance with documentation requirements.
• Patient/physician satisfaction.

**Respiratory Therapy**
• Compliance with the protocols for patient management.
• Patient incidents.
• Treatments missed.
• Discrepancy between request and treatment given.
• Promptness in responding to requests.
• Quality of management of critical procedures.
• Recognition of changes in patient’s situation requiring change in therapy.
• Patient/physician satisfaction.
• Compliance with infection control and safety procedures.
• Compliance with documentation requirements.
• Complications during care.
• Waiting time for outpatients.
• Patient refusal of treatment.

**Coronary Care/Intensive Care Unit**
• Patient incidents.
• Patient complaints.
• Physician complaints.
• Death rates.
• Rate of infections acquired in the unit.
• Medical errors.
• Successful attempts at cardiopulmonary resuscitation.
• External transfer of patients.
• Undocumented administration of drugs.
• Narcotics lost/misplaced.

**Special Care Units**
• Relevance of patient evaluations.
• Patient incidents.
• Compliance with infection control and safety procedures.
• Recognition of symptoms that need to be reported to physician.
• Compliance with documentation requirements.
• Appropriateness of emergency treatment.
• Comparison of regular requests with treatment administered.
• Compliance with protocols for patient management.
• Treatment complications.
• Patient/physician satisfaction.

**Home Care Services**
• Suitability of the services provided.
• Requests for versus treatment provided.
• Patient/family satisfaction.
• Promptness in responding to requests for service.
• Patient incidents.
• Documentation of measurable treatment targets.
• Readmission to the hospital.
• Compliance with infection control and safety procedures.
• Documentation of instructions given to patient.
• Achievement of treatment targets.
Central Supply

- Items out of stock.
- Interruptions in sterilization processes.
- Storage errors.
- Physician complaints.
- Personnel complaints.
- Positive cultures from sterilizers.

Accounting Office

- Accuracy in the billing process.
- Number of charges from different sections.
- Failure to include delayed charges.
- Rate of re-billing.
- Promptness in billing (time elapsed between patient discharge and billing).
- Patient complaints.

Housekeeping

- Time taken to clean patient rooms.
- Cleaning inspections.
- Compliance with infection control and safety procedures.
- Number of times repeat cleaning is required.
- Time elapsed between request and performance of services.
- Patient satisfaction.
- Compliance with state health standards.
- Employee accidents.

Food and Nutrition

- Patients receiving inadequate diet.
• Promptness in responding to requests.
• Correct tray contents.
• Patient incidents.
• Amount of food wasted.
• Compliance with infection control and safety procedures.
• Accuracy of nutritional evaluations.
• Patient satisfaction.

INDICATORS BY MEDICAL SPECIALTY

Anesthesia

• Appropriate selection of anesthesia.
• Documentation of pre-and post-operative visits.
• Compliance with documentation requirements.
• Promptness of pre-and post-operative visits.
• Trauma induced by anesthesia.
• Deaths during perioperative period.
• Compliance with infection control and safety procedures.
• Availability of emergency treatment.
• Delays in surgical intervention caused by anesthesiologist.
• Delays of more than “x” minutes before start of a surgical intervention.
• Claims of professional incompetence.
• Cancellation of scheduled surgery.

Other Specific Clinical Indicators Related to Anesthesia

• Mortality within a given period of time following anesthesia.
• Failure of patient to recover from general anesthesia within a given period of time.
• Injury to the brain or spinal medulla within a given period of time following anesthesia.
• Development of peripheral neurological deficiency within a given period of time following anesthesia.

• Fulminant pulmonary edema within a given period of time following anesthesia.

• Odontological injury during anesthesia.

• Unscheduled admission to the hospital within a given period of time following an outpatient procedure that required anesthesia.

• Unscheduled admission to the intensive care unit within a given period of time following administration of anesthesia.

• Aspiration of gastric contents with development of radiological results typical of aspiration pneumonitis related to anesthesia.

• Cardiac arrest temporally related to anesthesia.

• Clinically apparent acute myocardial infarction temporally related to anesthesia.

• Development of headache after dural perforation related to anesthesia.

• Failure, poor operation, or disconnection of equipment.

• Failure of intubation.

• Injury to the trachea.

• Deficient local anesthesia requiring general anesthesia.

• Failure to recover from general anesthesia within a given period of time.

• Mortality related to anesthesia.

• Ocular injury during anesthesia.

• Onset of malignant hyperthermia.

• Prolonged labor secondary to epidural anesthesia.

• Prolonged recovery (72 hours) after general anesthesia.

• Pulmonary aspiration.

• Reintubation in the Recovery Room.

• Repeated cannulation.

• Repeated epidural anesthesia.
• Respiratory arrest related to anesthesia.

**Risk Factors in Anesthetic Care**

• Age
• Sex
• Height
• Weight
• Considerations related to pregnancy, including time of gestation.
• Physical state, as defined in the guidelines of the Society of Anesthesiologists.
• Diagnosis prior to anesthesia.
• Type of surgical procedure.
• Duration of surgical intervention.

**General Surgery**

• Repetition of any procedure during the same admission.
• Postoperative atelectasis.
• Injury from cauterization.
• Postoperative thrombosis of a vena profunda.
• Perforated appendix.
• Return to the operating room due to injury occurring after surgery.
• Postoperative thromboembolism.
• Postoperative infection of the urinary tract.
• Hematoma of the incision.
• Infection of the incision.

**Same-Day Surgery**

• All cancellations.
• Cancellation due to emergency.
• Cancellation at request of patient.
• Cancellation due to illness of staff.
• Cancellation due to illness of patient.
• Postoperative infection.
• Unscheduled admission for the night.

**Others**

• Discharge against medical advice.
• Reaction to drugs or transfusion.
• Incident in Operating Room.
• Postoperative complications.
• Invasive diagnostic procedure repeated during the same admission.
• Unplanned removal or repair of normal body part during surgery (without consent).
• Appropriate use of hemoculture sensitivity in treatment of bacterial sepsis.
• Serious errors in administration of drugs resulting in death or significant morbidity.
• Development of complications associated with substandard methods of administration and monitoring specific drugs.
• Development of infections related to the use of intravascular devices in special care units.
• Development of pneumonia in patients treated in special care units.
• Worsening of bedsores (decubitus ulcers or eschars).
• Development of infections in wounds after clean or clean-contaminated surgical procedures.
• Unscheduled admission to hospital after outpatient surgery or specific procedures.
• Unscheduled readmission to hospital shortly after a surgical intervention performed in the hospital.
• Unscheduled admission to hospital shortly after a surgical intervention or specific outpatient procedures performed outside the hospital.
• Promptness in performing antibiotic prophylaxis during specific surgical procedures.
• Amputation of “diabetic foot” (indicates poor follow-up at primary care level).
• Inadequate utilization of antibiogram in treatment of bacterial sepsis.

• Major errors in medication resulting in death or serious morbidity.

• Death of patients with specific medical conditions during hospitalization or within 30 days after admission if the death occurs in the institution to which the patient was transferred.

• Death of patients after specific surgical procedures during hospitalization or within 30 thirty days after admission if the death occurs in the institution to which the patient was transferred.

• Death of patients treated in the hospital for injuries occurring immediately prior to treatment when the death occurs within 30 days after the injury or during hospitalization required because of the injury.

Otolaryngology/Endoscopy

• Postoperative hematoma.

• Transfusions.

• Injury following tracheal intubation.

Oral/Maxillofacial/Dental

• Slow healing.

• Skin loss.

• Unforeseen procedure for airway.

• Unscheduled discharge.

Internal Medicine

• Acute myocardial infarct in patients under 50 years of age.

• Discharge against medical advice.

• In-hospital incident.

• Injury of organ or body part during invasive procedure.

• Non-identifiable pain that did not exist on admission.

• Renal failure–creatinine elevated above level at admission.

• Invasive diagnostic procedure repeated during the same admission.
**Pediatrics**

- Cardiac or respiratory arrest.
- Congenital problems of the newborn.
- Fever of unknown origin.
- Newborn requiring oxygen for more than 24 hours after birth.
- Newborn requiring parenteral antibiotics.
- Error in or reaction to medication.
- Neonatal seizure.
- Neonatal sepsis.
- Newborn with significant anomalies.
- Injury to newborn.
- Patient discharged without written outpatient instructions.
- Phototherapy due to bilirubinemia.
- Parenteral versus oral hydration.
- Readmission to hospital within 72 hours after discharge.
- Suspected sexual molestation or abuse.
- Transfer to special care unit after 24 hours.
- Unforeseen/anomalous diagnostic results after discharge of patient.
- Pneumonia consequent to diarrheal syndrome (indicates poor follow-up at primary care level).

**Clinical Indicators in Obstetrical Care**

- Induction of delivery based on clinical indications other than diabetes, premature rupture of membranes, pregnancy-related hypertension, gestation to term, retarded intrauterine growth, cardiac disease, isoimmunization, death of the fetus, or chorioamnionitis with or without cesarean section.
- Primary cesarean section because of lack of progress.
- Successful or failed vaginal delivery after cesarean section.
- Delivery by repeated planned cesarean section of newborns weighing less than 2500 grams or with disease of the hyaline membrane.
• Induced delivery of a newborn weighing less than 2500 grams or with disease of the hyaline membrane.

• Eclampsia.

• In-hospital treatment with antibiotics starting 24 hours or more after vaginal delivery to term.

• Excessive loss of maternal blood, except because of ruptured or early placenta, as indicated by need for transfusion of red cells, hematocrit level of less than 22 or hemoglobin under 7, or a drop of more than 11 in hematocrit or more than 3.5 in hemoglobin.

• Maternal stay of more than 5 days following vaginal delivery or more than 7 days following cesarean section.

• Readmission of the mother within 14 days after delivery.

• Death of the mother 42 days after delivery.

• Death during in-hospital delivery of a fetus weighing 500 grams or more.

• Perinatal death of a newborn weighing 500 grams or more.

• Death of a newborn weighing between 750 to 999 grams in a hospital with a neonatal intensive care unit (NICU).

• Delivery of a newborn weighing less than 1800 grams in a hospital without an NICU.

• Transfer of a newborn to the NICU at another hospital.

• Full-term newborn admitted to an UCIN.

• Diagnosis of mass aspiration syndrome.

• Diagnosis of traumatism during birth.

• Full-term newborn with clinically apparent sudden convulsions prior to discharge from hospital.

• Number of abortions in Emergency Room (information on origin and residence of the patient for comparison with community family planning programs).

Other Obstetrical Events

• Injury to the bladder during cesarean section.

• Blood loss of more than 1000 cc.

• Maternal cardiac/respiratory arrest.

• Cesarean section procedure lasting longer than 30 minutes.
• Delivery assisted by a person without obstetrical credentials.
• Delivery of very premature newborn in institution without a neonatal intensive care unit.
• Appearance of clinically apparent seizures before discharge from hospital.
• Diagnosis of meconium aspiration syndrome in the newborn ward.
• Diagnosis of specific types of birth trauma.
• Discharge against medical advice.
• Emergency hysterectomy after delivery.
• Fetal monitor not available during delivery.
• Injury caused by forceps.
• Fourth-degree laceration or extension of episiotomy.
• Hematocrit level lower than 28 percent.
• Disease of the hyaline membrane after repeated elective cesarean section.
• Induction for reasons other than those specified, with and without subsequent cesarean section.
• Death during in-hospital delivery except in the case of extreme premature birth or significant birth defects.
• Injury to organ or body part.
• Transfusion of red blood cells during or after delivery except in the case of abruptio placenta or placenta previa.
• Intrauterine fetal death (less than 20 weeks/delivery in waiting room outside Delivery Room).
• Maternal diabetes controlled with insulin.
• Delivery with high forceps.
• Neonatal death.
• Neonatal death of high-risk newborns in institutions with intensive neonatal care unit.
• Neonatal sepsis.
• Newborn weighing less than 2000 grams.
• Newborn weighing less than 2500 grams.
• Newborn weighing more than 4500 grams.
• Perinatal mortality except in the case of extreme premature delivery.
• Hemorrhage following delivery.
• Infection following delivery.
• Precipitation of delivery.
• Preeclampsia.
• Premature delivery after repeated elective cesarean section.
• Primary cesarean section (check whether the following criteria are included in the record:)
  • Placenta previa
  • Deficient cephalopelvic ratio
  • Lack of progress
  • Fetal compromise
  • Active herpes
  • Breech presentation
  • Preeclampsia
  • Stillbirth
  • Maternal death
  • Apgar score of 6 or lower at 5 minutes\textsuperscript{4}
  • Prolonged maternal stay based on indications from vaginal delivery or cesarean section.
  • Rate of vaginal or cesarean deliveries attempted or performed.
  • Resuscitation of full-term newborn with intubation.
  • Scalp pH of less than 7.2.
  • Major birth trauma (fracture, birth palsy, cephalohematoma).

\textsuperscript{4} APGAR: Evaluation of the physical state of the newborn after delivery, stating numerical values for: heartbeat, respiratory stress, muscle tone, irritability reflexes, and skin color.
• Stillbirth (at more than 20 weeks).
• Stillbirth (at more than 24 weeks or 500 grams).
• Surgical complications as indicated in postoperative report.
• Non-premature newborn admitted to a neonatal intensive care unit.
• Non-premature newborn with seizure prior to discharge from hospital.
• Unscheduled return to Operating/Delivery Room.
• Unscheduled transfer to neonatal intensive care unit.
• Complications involving incision.
• Hematoma of the vagina/vulva.

**Urology**

• Admission due to scrotal pain within two weeks after vasectomy.
• Hospitalization due to infection of the urinary tract or hemorrhage within two weeks after cystoscopy.
• Reaction to endovenous contrast requiring hospitalization.
• Postoperative renal hemorrhage.
• Postoperative scrotal hematoma.
• Unscheduled return to Operating Room.
• Postoperative infection of the urinary tract.

**Orthopedics**

• Gangrene.
• Defective union or failure of fracture to mend.
• Infection of wound.

**Rehabilitation**

• Patient incidents.
• Compliance with documentation requirements.
• Relevance of patient evaluations.
• Attainment of specific targets.
• Measurement of treatment targets.
• Request for versus treatments performed.
• Promptness in responding to requests for services.
• Compliance with infection control and safety procedures.
• Patient/physician satisfaction.
• Waiting period for patients.
• Delayed visits.
• Relevance of the treatment program.

**Occupational Medicine**

• Any referral of patient for admission (unscheduled).
• Injury resulting from treatment (splint, plaster cast).
• Unscheduled return to the clinic within 24 hours with the same complaint.
• Infection of wound.

**Dermatology**

• Treatment for skin cancer not completed within 6 weeks.
• Postoperative complications.
• Reaction to local anesthesia.
• Request for same-day consultation not attended to within 24 hours.
• Second-degree burn caused by phototherapy.

**Psychiatry**

• Escape.
• In-hospital incident.
• Injury associated with use of restraints.
• Error in medication.
• Failure of staff to comply with hospital policy regarding means used of restrain patients.
• Indication of or attempt at suicide while patient is hospitalized.
• Unexpected reaction to drugs.
• Unscheduled transfer to another hospital for intensive care.

Alcoholism Rehabilitation Service

• Treatment failure.
• Treatment-related injury.