
Patient safety assessment manual

Third edition



**World Health
Organization**

REGIONAL OFFICE FOR THE **Eastern Mediterranean**

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► Foreword

Patient safety is a fundamental principle of quality highlighted in the global health agenda. It is an essential requirement for establishing resilient health care systems that can meet people's needs by giving foundations of quality health care services. Patient safety was highlighted by the Seventy-second World Health Assembly in resolution WHA72.6 on *Global action on patient safety* in May 2019, which endorsed the establishment of an annual World Patient Safety Day, to be observed globally on 17 September.

Patients might be at risk of harm if they receive non-evidence-based care, which could be delayed, inefficient, inequitable, of poor quality and cause financial burden for them and their families. It is unacceptable that unsafe health care services still lead to 134 million adverse events annually in low- and middle-income countries, accounting for nearly 2.6 million deaths. In the Eastern Mediterranean Region, evidence shows that up to 18% of hospital admissions are associated with adverse events, 80% of which are considered preventable. We have to recognize that unsafe care not only causes harm at the patient level, but also drains resources, diminishes the population's trust in the health system and hinders progress towards universal health coverage (UHC) at national, regional and global levels.

WHO is therefore prioritizing patient safety as an avenue to improve the overall quality and safety of health care in the Region. One key intervention, the Patient Safety Friendly Hospital Initiative (PSFHI), was launched in 2011 with the publication of the first edition of the *Patient safety assessment manual*. With later revisions and updates, this WHO-led initiative developed into the Patient Safety Friendly Hospital Framework (PSFHF) to promote patient safety practices in health care facilities as a core element of services provided. The PSFHF introduces a comprehensive set of standards and a framework through which hospitals can deliver safer patient care. It assesses hospitals' performance from a patient safety perspective, builds capacities of staff in patient safety and actively integrates patients and communities in improving health care safety.

Patient safety is a continuous cycle, lessons are learned daily and we must be flexible and adapt implementation frameworks to meet new challenges. Since we started to develop this edition in early 2019, COVID-19 has dramatically changed the way health care services are provided. While the PSFHF covers all the key elements required, it is crucial to enhance these standards to include the management of COVID-19 and similar pandemics. Therefore, a supplement to the manual will be published by early 2021 that is fully aligned with the PSFHF, focusing on health care facility preparedness to manage pandemics.

Patient safety standards should be adopted and institutionalized within all health care systems throughout the countries of the Region. To this end, I hope that this third edition of the *Patient safety assessment manual*, together with the COVID-19 supplement, will provide a valuable resource for ministries of health, as well as academic institutions and professional bodies, in building their technical capacity.

Dr Ahmed Al-Mandhari
WHO Regional Director for the Eastern Mediterranean

► **Preface to the third edition**

The *Patient safety assessment manual* was first published in 2011, revised in 2015 and the second edition published in 2016. It comprises a set of standards that covers the different domains of patient safety. The information on the standards is collected on a continuous basis and reflects current health care practice and the best practice evidence-based interventions. The corresponding criteria are revised every three to four years.

In this third edition, the total number of assessment criteria is 134 as compared to 139 in the second edition. Similar requirements have been combined into single standards and the wording of some standards has been modified. Other standards have been added based on their importance for patient outcomes and with consideration to their alignment with WHO initiatives to promote patient safety. The full set of amendments is detailed in Table 6.

A COVID-19 supplement will be published by early 2021 that will be fully aligned with this third edition of the manual.

To participate in the PSFHF, hospitals are assessed against all 134 criteria; for those who want to check preparedness for COVID-19, the criteria within the COVID-19 supplement can also be applied.

This manual is the result of collaborative work between the WHO Regional Office for the Eastern Mediterranean and regional experts.

► Glossary

Accountability: Responsibility and requirement to answer for tasks or activities. This responsibility may not be delegated and should be transparent to all stakeholders.

Audit: A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements.

Best practice: An approach that has been shown to produce superior results, selected by systematic process and judged as exemplary, or demonstrated as successful. It is then adapted to fit a particular organization.

Bundle: A bundle or sometimes referred to as a care bundle, is a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices.

Chief executive: The person appointed to act on behalf of a governing body in the overall management of the organization. Various other titles may be used, including general manager, executive director or hospital manager, chief executive officer (CEO).

CLABSI: Central line-associated bloodstream infection

Clinical governance: A framework under which hospitals are accountable for continuously monitoring and improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care should flourish.

Code of conduct: Documented set of agreed principles that informs all parties of responsibilities and expectations under the code.

Community: Individuals, families, groups and organizations that usually reside in the same locality.

Competency: The knowledge, skills, abilities, behaviours, experience and expertise to be able to perform a particular task and activity.

Confidentiality: The right of individuals to keep information about themselves from being disclosed.

Corporate governance: The framework of rules and practices by which a board/chief executive officer (CEO) ensures accountability, fairness and transparency in a company's relationship with its stakeholders.

Culture: The shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.

Document control system: A planned system for controlling the release, change and use of important documents within the organization, particularly policies and procedures.

DVT: Deep venous thrombosis

Ethics: Acknowledged set of principles that guides professional and moral conduct.

Goals: Broad statements that describe the outcomes an organization is seeking and provide direction for day-to-day decisions and activities.

HAI: Hospital-acquired infection

ICD-10, ICD-11: International Classification of Diseases, 10th and 11th editions.

Improvement science: Improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement.

Incidents: Events that are unusual, unexpected, may have an element of risk or that may have a negative effect on clients, groups, staff or the organization.

Information: Data that are organized, interpreted and used. Information may be paper based or electronic.

Informed consent: The information given to the patient ensuring all risks, benefits and potential side-effects are explained and in advance of the procedure and any sedation.

Information management: The collection, management and distribution of information.

IPC: Infection prevention and control

KPIs: Key performance indicators

Mission: A broad written statement that articulates the organization's purpose and scope.

Objective: A target that must be reached if the organization is to achieve its goal.

Orientation: The process by which staff are introduced to a new role and work environment.

Operations plan: A plan setting out the annual operatives of how the strategic plan will be operationalized; can also be called an annual plan.

PE: Pulmonary embolism

Policy: A written operational statement that formalizes the approach to tasks that is consistent with the organizational objectives.

Polypharmacy: Defined as the chronic co-prescription of several drugs and is associated with a high rate of adverse drug reactions, mainly from drug–drug interactions (the ability of a drug to modify the action or effect of another drug administered successively or simultaneously).

Procedure: A written set of instructions conveying the approved and recommended steps for a particular act or series of acts.

Process: A series of actions or steps taken in order to achieve a particular end.

PSFHF: Patient Safety Friendly Hospital Framework.

Quality improvement plan: A plan that outlines quality improvement initiatives, including the proposed actions, timelines and responsible individual(s).

Research: Contribution to an existing body of knowledge through investigation, aimed at the discovery and interpretation of facts.

Risk: The probability of danger, loss or injury.

Risk management: A systematic process of identifying, assessing and taking action to prevent or manage clinical, administrative, property and occupational health and safety risks in the organization.

Risk management framework: A set of components that provides the foundations and organizational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management throughout the organization.

SBAR: Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

Strategic plan: A formalized plan that establishes the organization's overall goals.

Survey: External peer review that measures the performance of the organization against an agreed set of standards.

Surveyor: An external peer reviewer of organizational performance against agreed standards.

UHC: Universal health coverage

UTI: Urinary tract infection

VAP: Ventilator-associated pneumonia

Values: Principles, beliefs or statements of philosophy that guide behaviour, which may include social or ethical issues.

Vision: A declaration of an organization's objectives, intended to guide its internal decision-making.

WHO: World Health Organization

► Introduction

Overview

Patient safety is a human right and a fundamental principle of health care, yet 20 years since the seminal *To err is human*¹ statistics show very little progress has been made. According to the World Health Organization (WHO), patient safety is now a major global burden with 421 million admissions to hospital a year resulting in harm to around 10% of those patients. This rises to 18% in the WHO Eastern Mediterranean Region, where 83% of these events are preventable. *To err is human*² put the responsibility for patient safety in the hands of health care professionals and challenged them to reduce medical errors by 50% in five years. While small pockets of success have been noted in the areas of hospital-acquired infection (HAI) and medication safety, health care professionals still have not learned sufficiently from their mistakes and the frequency of preventable harm remains too high.³

There are vast quantities of research available on the effectiveness of interventions to promote solutions for patient safety. Similar to Bates and Singh,⁴ Vincent and Amalberti⁵ acknowledge not enough progress has been achieved in the last two decades, reflecting that most current safety initiatives are focused on improving the system in isolation of what happens in the real world. These authors sought to show how methods need to be developed, aimed at managing safety and risks, in a complex health care system. Most importantly, they place the patient's perspective at the centre of their approach, defining patient safety as "the management of risk over time". What is now very clear is there is not one answer, but a finite list of proven solutions, that will reduce safety incidents and promote quality.⁶

WHO has recognized the importance of patient safety and prioritized it as a public health concern. Universal health coverage (UHC), which is not limited to ensuring access to care alone but rather access to quality safe care, is a target of the 2030 Sustainable Development Goals. In May 2019, the Seventy-second World Health Assembly recognized patient safety as a key priority and committed to taking concerted action to reduce patient harm in health care settings in resolution WHA72.6 on *Global action on patient safety*, declaring that patient safety will enable UHC to be delivered, while reassuring communities that they can trust their health care systems to keep them and their families safe. Systems for evaluating compliance with patient safety standards will guide Member States when planning and mobilizing resources for UHC, and offer validation of quality models of care. Resolution WHA72.6 also endorsed the establishment of the WHO Global Patient Safety Day, to be marked annually on 17 September, thus underlining global solidarity and raising awareness of patient safety as a worldwide health priority.

In response to the pressing need for the development of interventions that address lapses in patient safety, the WHO Regional Office for the Eastern Mediterranean launched the Patient Safety Friendly Hospital Initiative (PSFHI) in 2011 with the publication of the first edition of the *Patient safety assessment manual*. This initiative was later transformed into a framework, the Patient Safety Friendly Hospital Framework (PSFHF), which involves the implementation

¹ Kohn LT, Corrigan JM, Donaldson MS, editors. *To err is human: building a safer health system*. Washington (DC): Institute of Medicine Committee on Quality of Health Care in America; 1999.

² *Ibid.*

³ Bates DW, Singh H. Two decades since *To err is human*: an assessment of progress and emerging priorities in patient safety. *Health Aff (Millwood)*. 2018;37(11).

⁴ *Ibid.*

⁵ Vincent C, Amalberti R. *Safer healthcare: strategies for the real world*. New York (NY): Springer Open; 2016.

⁶ Nicklin W, Fortune T, van Ostenberg P, O'Connor E, McCauley N. Leveraging the full value of accreditation. *Int J Qual Health Care*. 2017;29(2).

of a set of patient safety standards in hospitals. Compliance with the standards ensures that patient safety is accorded the necessary priority and that facilities and staff implement best practices. The first set of PSFHF standards was developed and reviewed by a group of regional and international experts. The Framework was pilot-tested in seven countries of the Region (Egypt, Jordan, Morocco, Pakistan, Sudan, Tunisia and Yemen) and experts were trained to conduct an initial baseline assessment, based on the standards and implementation guidelines, in one pilot hospital in each of the countries. The second edition of the *Patient safety assessment manual* was published in 2016.

Since 2011, the PSFHF has expanded to other WHO regions, and countries that endorse the PSFHF include Afghanistan, Islamic Republic of Iran, Libya, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Tunisia, and Yemen. Due to its success, the WHO Regional Director for the Eastern Mediterranean, Dr Ahmed Al-Mandhari, in 2019 declared that expanding the adoption of the PSFHF is now among his 10 priorities for improving patient safety and the quality of care in the Region.

As a result of an extensive review that commenced in April 2019, this third edition of the WHO *Patient safety assessment manual* updates the standards to bring them into line with current best practice and WHO guidance. A literature review was undertaken to identify any new themes or changes in each of the patient safety domains. This included identifying the relevant updated WHO guidelines to support implementation of the standards. Client, facilitator and surveyor evaluations of the PSFHF were also sought, collated and analysed and, together with the literature review, were used to guide the revision of the manual. An expert review of the draft standards was conducted remotely.

Using the RUMBA principles, the PSFHF standards were then pilot tested in December 2019. RUMBA principles ensure the criteria are **r**elevant, **u**nderstandable, **m**easurable, **b**eneficial and **a**chievable.

Table 6 outlines the changes and differences between this third edition and the second edition. A total of 15 new criteria have been introduced, including corporate governance, mission statements, staff safety, right to refuse treatment, communication, information management and technology, and the management of ethical concerns. A number of the criteria have been upgraded from core to critical, which now total 25. Table 3 provides a list of all critical criteria. The format of the standards has been changed to reduce duplication and offer support to both organizations and surveyors in how to validate compliance with the criteria.

Changes in the third edition have also been made to the assessment methodology to improve consistency and fairness across surveys. The 3-point rating scale was reviewed and based on feedback was not changed; however, guidance to assist surveyors to differentiate between each level has been improved. Guidance on the rating scale will be further addressed in the PSFHF Surveyor Training Programme. This third edition will be available from the end of 2020 and all health care facilities will be assessed against this edition from 2021 onwards. The COVID-19 supplement will be offered in all surveys by the end of 2021.

Patient safety friendly hospital assessment

Patient safety standards are a set of requirements that is critical for the establishment of a patient safety programme at the hospital level. The requirements provide a framework that enables hospitals to assess patient care from a patient safety perspective, build capacity of staff in patient safety and involve consumers in improving health care safety.

Patient safety friendly hospital assessment is a mechanism developed to assess patient safety in hospitals. These standards are applicable to the whole hospital and not a part or a

specific service of it. They provide institutions, at the system level, with a means to determine the level of patient safety, whether for the purpose of initiating a patient safety programme or as part of an ongoing programme. The assessment is voluntary and is conducted through an external, peer review survey. The WHO Regional Advisory Group on Patient Safety, as the primary assessment team, began the process. The group assessed hospitals to determine whether or not they complied with the WHO patient safety standards and patient safety performance indicators, followed by capacity-building of national country teams as patient safety external assessment teams.

Since the last edition in 2016, 260 surveyors have been trained in Pakistan, Qatar, Oman, Saudi Arabia and Tunisia. Moreover, support is being provided to national hospital teams in Libya and Yemen through national experts who were previously trained on the PSFHF. Assessment has several benefits for hospitals. It demonstrates to the public a commitment and accountability regarding patient safety. It offers a key benchmarking tool, identifies opportunities for improvement and encourages improvement to attain standard targets. Finally, it provides motivation for staff to participate in improving patient safety. The ultimate goal of the Framework is to improve the level of patient safety in hospitals by creating conditions that lead to safer care, thus protecting the community from avoidable harm and reducing adverse events in hospital settings.

The PSFHF can be used with other patient safety tools and other forms of external evaluation. The difference between the PSFHF and other external evaluation programmes is that it concentrates on patient safety and the emphasis is on continuous improvement rather than an award.

Role of WHO in the PSFHF

The PSFHF is a WHO framework aimed at assisting institutions within countries to launch a comprehensive patient safety programme. Ultimately, it is hoped that this framework will be owned by the institutions and ministries of health. The *Patient safety assessment manual* provides the necessary tools for professional associations, regulatory, accrediting or oversight bodies, and ministries of health to improve patient safety. The award of a certificate or award of achievement is at the discretion of the national supervising body, such as the ministry of health. However, hospitals can also use the manual to self-assess and use the gap analysis to form a quality improvement programme to improve patient safety.

Structure and organization of the manual

The *Patient safety assessment manual* is designed for health care organizations, surveyors and facilitators. It is organized into three sections: (1) overview and assessment methodology; (2) patient safety standards (the 21 standards); and (3) patient safety friendly hospital assessment tools.

Section 1 contains information on how to use the standards; how the surveyors conduct the assessment; the rating scale; how the level of achievement is calculated; and what changes have been made in the third edition of the *Patient safety assessment manual* compared to the second edition.

Section 2 contains the patient safety standards, which are divided into five domains: A. Leadership and management; B. Patient and public involvement; C. Safe evidence-based clinical practice; D. Safe environment; and E. Life-long learning. Each domain comprises several standards, 21 in total. Each standard contains a number of criteria, 134 in total. A criterion can be critical, core or developmental, and different types of criteria are distributed among the five domains (Table 1).

Table 1. Distribution of the criteria stratified by the PSFHI five domains

Domains (third edition)	Critical criteria	Core criteria	Developmental criteria	Total criteria in each domain
A. Leadership and management (6 standards: A1–A6)	7	26	3	36
B. Patient and public involvement (7 standards: B1–B7)	2	22	7	31
C. Safe evidence-based clinical practice (4 standards: C1–C4)	14	24	2	40
D. Safe environment (2 standards: D1–D2)	1	20	1	22
E. Lifelong learning (3 standards: E1–E3)	1	2	2	5
Total	25	94	15	134

Section 3 contains a list of documents that hospitals need to prepare, a set of structured interviews, guidelines for observations, a sample survey schedule and a report template.

► Section 1. Overview of the Patient Safety Friendly Hospital Framework (PSFHF)

The hospital

All hospitals are welcome to participate in the PSFHF, whether public or private. In some countries, hospitals are selected based on criteria developed by the respective ministry of health, in collaboration with WHO country offices. The WHO Regional Office is making concerted efforts to expand the number of trained surveyors and to encourage ownership of the Framework by ministries of health or other recognized national agencies. When a country signs up to the PSFHF, the Regional Office can provide initial assistance by training the first group of surveyors and facilitators. The first group of hospitals to be assessed will be undertaken by a mix of national surveyors and international experts. The Regional Office will continue to provide technical support as and when required.

Section 1 contains information on how to use the standards, how the surveyors conduct the assessment, the rating scale, how the level of achievement is calculated and what changes have been made in this third edition of the *Patient safety assessment manual* compared to the second edition.

The first task for the hospital is to review the standards that will be used for the survey at least six months before the assessment visit. While not a requirement, it is advised that an initial self-assessment of performance in relation to the standards be conducted, recommending that a small team is tasked with working through the self-assessment process. The hospital will be responsible for collating all the evidence and identifying any areas for particular attention. At the end of this process, the hospital will have a gap analysis with identified actions where further work is required and a list of documents that demonstrates their compliance to each criterion.

Following each criterion is a small list of suggested evidence of compliance. This is suggested evidence only and hospitals may decide to present other evidence that demonstrates their compliance. Evidence should be provided for each criterion and must be in English. If any actions are required to achieve better compliance, then they should be clearly documented. All evidence of compliance (documents) should be presented in a user-friendly system that the surveyors can easily navigate.

The hospital management team is encouraged to inform the public, staff and patients that patient safety friendly hospital assessment evaluators will be assessing the hospital on the specified dates and should inform them of the purpose of the PSFHF.

Interpreting the standards

All patient safety domains and standards follow the same format (Table 2). Each standard has an intent statement that identifies the high-level outcome for that standard. All standards have a set of criteria. Each criterion is followed by a list of documents that can be used to validate compliance to the criterion. This is not an exhaustive list, as structures and processes differ in different countries, instead it should be used as a guide to determine

how to validate compliance to a criterion. There are certain documents that all health care organizations should submit with an application for PSFHF assessment (see Section 3). These include corporate documents such as strategic and operational plans (structure), policies and procedures (process) and evidence of measurement and audit (outcome).

Table 2. Format for all patient safety domains and standards

Domain A. Leadership and management		
A.1 Standard. Leadership and governance are committed to patient safety		Guidance for evidence of compliance
Critical criteria	A.1.1.1	
	A.1.1.2	
	A.1.1.3	
Core criteria	A.1.2.1	
	A.1.2.2	
	A.1.2.3	
Developmental criteria	A.1.3.1	
	A.1.3.2	

Critical criteria have been prioritized as issues that must be urgently addressed for a hospital to provide safe care. In the third edition, there are 25 in total and all are based on evidence from the literature of common problems that arise, such as governance, communication, hand hygiene, staff competency and staff training. Addressing all 25 criteria is a good place for a hospital to start their quality journey (Table 3).

Table 3. The 25 critical criteria for the third edition

Critical criteria
A.1.1.1 The hospital has a strategic plan with patient safety as a priority.
A.1.1.2 There is a recognized corporate and clinical governance/leadership system within the hospital.
A.1.1.3 The leadership promotes a culture of patient safety by conducting different activities, including monthly patient safety walk-rounds to identify and take action on safety issues.
A.2.1.1 The leadership ensures there is a designated qualified senior staff member with responsibility, accountability and authority for patient safety.
A.4.1.1 The leadership ensures the availability of essential functioning equipment and supplies.
A.5.1.1 The leadership ensures the provision of sufficient numbers of competent staff to deliver safe patient care at all times.
A.5.1.2 There is a defined process to ensure all clinical staff are registered to practise with an appropriate body.
B.2.1.1 Informed consent is obtained, before a procedure requiring informed consent, by trained staff in a manner and language the patient or authorized person can understand.
B.3.1.1 The identification process used throughout the hospital requires at least two ways in which to identify a patient.
C.1.1.1 The hospital leadership maintains effective channels of communication throughout the hospital, including for urgent critical results, with a designated channel for safety issues
C.1.1.2 The hospital implements the use of a surgical safety checklist and conforms to guidelines, including WHO guidelines on safe surgery.

C.1.1.3 The hospital has systems in place to ensure hospital-wide recognition of and response to clinical deterioration.
C.1.1.4 The hospital minimizes use of verbal and telephone orders and transmission of results, and “read back” is practised where verbal communication is essential.
C.1.1.5 The hospital has systems in place for safe and thorough handover of patients between clinical teams and between shifts, with safe intra-hospital patient transfer.
C.1.1.6 The hospital implements safe childbirth guidelines and pathways of care.
C.2.1.1 The hospital has a coordinated programme for all infection prevention and control (IPC) activities that involves all disciplines.
C.2.1.2 The hospital ensures proper cleaning, disinfection and sterilization of all equipment.
C.2.1.3 There is a qualified, designated person responsible for all infection prevention and control (IPC) activities.
C.3.1.1 The hospital implements guidelines, including WHO guidelines, on safe quality blood and blood products.
C.3.1.2 The hospital ensures that patient blood samples for cross-matching are securely identified with two unique identifiers.
C.4.1.1 A licenced pharmacist provides a medication management system that addresses patient needs, meets applicable regulations and adheres to WHO guidelines.
C.4.1.2 The hospital keeps high concentrations of electrolytes in a safe place.
C.4.1.3 The hospital ensures availability of life-saving medications in proper quantities at all times.
D.2.1.2 The hospital conforms to guidelines on management of all types of hazardous waste, including sharps waste.
E.1.1.1 All hospital staff are provided with a patient safety orientation programme.

Core criteria are an essential set of standards with which a hospital should comply to become safe for patients. It is not compulsory to meet 100% of the core standards in order for a hospital to be in the PSFHF. However, the percentage of criteria complied with determines the level that the hospital attains. Furthermore, the percentage of core criteria fulfilled is important for internal benchmarking, to document improvement over time.

Developmental criteria are the requirements that a hospital should attempt to comply with, based on its capacity and resources, to enhance safe care.

Rating scale

A 3-point rating scale is used, with each criterion receiving a score of 1 if it is met, 0.5 if partially met, and 0 if not met. If a criterion is not applicable as it is not relevant to the clinical services provided by the hospital, then “not applicable” is scored, and the criterion is not considered in the final score. An example of a not applicable criterion is C.1.1.6: The hospital implements safe childbirth guidelines and pathways of care. If a hospital does not provide childbirth services, then this criterion is rated as “not applicable”. The rating scale is applied to each criterion and not at the standard level.

The PSFHF uses a peer review methodology and is not to be viewed as an audit. Therefore, rating requires experience on the part of the survey team. Ratings should be agreed by the whole survey team and the team should consider evidence from three different sources: documents; interviews; and observation. All this evidence and the surveyors experience are used to determine the final rating and ultimate achievement level.

The PSFHF surveyors are trained to be able to triangulate data from various sources. First,

by reviewing documents, some of which will be reviewed before going on site. Second, by interviewing key members of staff and patients. Finally, by observation of the environment and clinical care.

When applying a rating, the rationale and guidance shown in Table 4 are used to determine the level of compliance. If necessary, then the details of the improvements that are required to achieve a higher rating are added.

Table 4. Rules of scoring for evaluating each criterion

Rating	Score	Rational	Surveyor guidance
Met	1	80% or above samples comply	Add a recommendation or an opportunity for improvement (OFI)
Partially met	0.5	31–79% samples comply	Add an OFI or a recommendation to assist hospital to improve
Not met	0	Less than 30% samples comply	Add a recommendation and time scale

The survey

The onsite survey team and length of survey will vary according to the profile of the hospital (e.g. size, services and location). However, a consistent approach is applied to all similar types of organizations. The peer review survey team should comprise of no fewer than two surveyors. All teams should have at least one non-national surveyor on the team who is an experienced surveyor with the required competencies to lead the team. The team should be comprised of a mixture of corporate and clinical expertise.

A schedule of daily activities is prepared by the country level facilitator and agreed by the team leader that is sent in advance of the survey to the organizations for their input. The survey schedule lasts between two and four days (see the Suggested Survey Agenda in Section 3).

At the end of each survey the team discusses the high-level findings with the hospital team. This is followed by a report and recommendations to aid the hospital in making improvements in patient safety. The report is confidential and constructive and should be used as part of a hospital-wide quality improvement strategy to improve patient safety. The results of the survey may be made public or remain confidential at the discretion of the hospital management.

The surveyors

Surveyors are selected by the Regional Office and by the Ministry of Health or other national agencies intended to use these standards. All surveyors must be trained in the PSFHF before they can survey at the national level. The role of the survey team is to validate the hospitals compliance to the standards and provide constructive feedback on how to improve. The PSFHF utilizes a peer review methodology and a philosophy of continuous improvement through support and learning, therefore, the selection of appropriate surveyors is crucial to the success of the initiative.

The criteria for the selection of surveyors are:

- experts in the field with a minimum of 10 years working experience and postgraduate studies (medicine, governance and nursing);
- knowledge of the patient safety friendly hospital standards and survey methodology;
- knowledge and understanding of:
 - o health care systems
 - o health care education
 - o patient safety methods
 - o regulation, accreditation and quality improvement;
- analytical skills – effective information-handling, understanding and absorbing complex information, making decisions based on evidence and understanding clinical audit;
- cultural awareness – sensitivity and understanding of cultural, religious and demographic diversity;
- professionalism – adhering to high personal ethical standards, prioritizing patient safety, maintaining confidentiality, impartiality and objectivity, being enthusiastic, motivated and committed;
- interpersonal and communication skills – team collaboration, working constructively and respecting the views and contribution of others, interacting effectively with colleagues and patients, communicating effectively and courteously;
- fluent in spoken and written English; and
- good time management.

The criteria for selection of team leaders, in addition to all of the criteria for surveyors, are:

- previous experience of external evaluation surveys in health care or education;
- team member of at least two previous PSFHF surveys;
- previous experience leading an accreditation survey team or similar;
- ability to chair and lead; and
- conflict management skills.

Assessing and maintaining level of achievement

Hospitals are scored as patient safety friendly based on four levels of compliance, with Level 4 representing the highest attainable level (Table 5).

Table 5. Levels of achievement for the PSFHF

Hospital level	Critical criteria	Core criteria	Developmental criteria
Level 1	100%	Any	Any
Level 2	100%	60–89%	Any
Level 3	100%	≥90%	Any
Level 4	100%	≥90%	≥80%

The level of achievement is calculated in three stages.

1. Have all critical criteria met the level of compliance with a score of 80% or above (Met 1)? If yes, then:
2. What is the percentage of compliance to the core criteria? Finally:
3. What is the percentage of compliance to the developmental criteria?

The percentage of compliance is calculated by adding the ratings and then dividing by the total number of criteria. Unless a criterion is deemed not applicable by both the organization and the survey team, that criterion is not considered in the final score.

For example, there are six core criteria in standard A.5. Two criteria have scored 1, three criteria have scored 0.5 and one has scored 0. The total score for this standard is 3.5.

To calculate the % compliance to the core criteria each criterion should be scored 1, 0.5 or 0. The total numerical score should then be divided by 95.

To calculate the % compliance to the developmental criteria each criterion should be scored 1, 0.5 or 0. The total numerical score should then be divided by 15.

Example hospital 1:

- All 25 critical criteria have achieved full compliance
- The total score for core criteria is 80
 - $80/95 = 84\%$
- The total score for developmental criteria is 10
 - $10/15 = 67\%$
- Hospital 1 has achieved Level 2.

Example hospital 2:

- All 25 critical criteria have achieved full compliance
- The total score for core criteria is 82 with 4 not applicable criteria
 - $82/91 = 90\%$
- The total score for developmental criteria is 13
 - $13/15 = 87\%$
- Hospital 2 has achieved Level 4.

Once a hospital is recognized for its achievement to the PSFHF it is important that this compliance is maintained. It is suggested that internal evaluation be done on a quarterly basis and external evaluation on a 2-year basis for Level 1 and 2 hospitals and every three years for Level 3 and 4 hospitals.

Expansion at the national level

Following the initial baseline assessment of one hospital, selected by the Ministry of Health, the following steps are suggested for national expansion of the PSFHF:

- The Ministry of Health expresses commitment to and ownership of the Framework and selects up to 10 hospitals to participate in a launch and training workshop. Each hospital is approached by the Ministry of Health with a briefing on the Framework and a description of the process, with emphasis on its key objective to advance patient safety.

- Hospital management assigns a task force for the Framework, including a physician, nurse and administrator.
- A workshop on the Framework is held.
- The baseline assessment in each of the participating hospitals is initiated. Evaluators from the patient safety task force in one hospital perform the assessment in another hospital.
- The results of the baseline assessment are summarized in a report for each hospital (prepared by the evaluating team). Reports are shared with policy-makers at the Ministry of Health.
- The results are shared with each hospital and the hospital is provided with the key suggestions and recommendations for improvement. Technical support materials can also be provided by the Regional Office. The hospitals are notified that they will be re-assessed after nine months and are assisted in drafting an action plan for the initiative.
- A workshop is held at the national level with all stakeholders, including WHO country office, the Ministry of Health and representatives from public and private hospitals. Lessons learned from assessments can be implemented at the national level as well as in individual hospitals.

Table 6. Patient safety assessment manual: amendments to the second edition

Changes	Second edition	Third edition
Reworded	A.1.1.1 The hospital has patient safety as a strategic priority. This strategy is being implemented through a detailed action plan.	A.1.1.1 The hospital has a strategic plan with patient safety as a priority.
New		A.1.1.2 There is a recognized corporate and clinical governance/leadership system within the hospital. Critical criteria.
Merged	A.1.1.2 The hospital has a designated qualified senior staff member with responsibility, accountability and authority for patient safety.	Merged with A.2.1.1
Reworded	A.1.1.3 The leadership conducts regular patient safety executive walk-rounds to promote patient safety culture, learn about risks in the system, and act on patient safety improvement opportunities.	A.1.1.3 The leadership promotes a culture of patient safety by conducting monthly patient safety walk-rounds to identify and take action on safety issues.
Reworded	A.1.2.1 The hospital has an annual budget for patient safety activities based on detailed action plan.	A.1.2.1 The leadership provides resources, including an annual budget for patient safety activities based on a detailed action plan.
Reworded	A.1.2.2 The hospital follows a code of ethics.	A.1.2.2 The leadership provides a framework for ethical management that supports decision-making in clinical care and the management of research.
Reworded	A.1.2.3 The leadership assesses patient safety culture regularly on a quarterly basis.	A.1.2.3 The leadership assesses patient safety culture on an annual basis with resulting action plans reviewed every three months.
New		A.1.2.4 Every year the leadership acknowledges and celebrates WHO Hand Hygiene Day (5 May) and World Patient Safety Day (17 September).

Changes	Second edition	Third edition
New		A.1.3.1 The hospital's strategic plan has mission, vision and values statements that demonstrate a culture of patient safety. Developmental criteria.
Reworded	A.2.1.2 A designated qualified person co-ordinates patient safety and risk management activities (middle management).	A.2.1.1 The leadership ensures there is a designated qualified senior member with responsibility, accountability and authority for patient safety.
Reworded	A.2.1.1 The hospital conducts regular monthly morbidity and mortality (M&M) meetings.	A.2.2.6 The hospital conducts bi-monthly morbidity and mortality (M&M) meetings.
Merged	A.2.2.1 Patient safety is reflected in the organizational structure of the hospital.	A.2.1.1 The leadership ensures there is a designated qualified senior member with responsibility, accountability and authority for patient safety.
Reworded and merged	A.2.2.2 Risk is managed reactively. Merged with E.3.3.2 The hospital has an implemented reporting system for adverse events, sentinel events and near misses.	A.2.2.5 A risk management framework, including a plan, policy and register, is used to identify and reduce adverse events and other safety risks to patients, visitors and staff.
Reworded	A.2.2.3 The hospital audits its safety practices on a regular basis.	A.2.2.2 The patient safety programme has a schedule of monthly audits and uses the results to improve patient services.
Reworded	A.2.2.4 The hospital has a multidisciplinary patient safety internal body or any other committee, whose members meet regularly to ensure an overarching patient safety programme.	A.2.2.1 The hospital has a multidisciplinary patient safety internal body/committee to guide all safety and risk within the hospital.
Reworded	A.2.2.5 The hospital regularly develops reports on different patient safety activities and disseminates them internally every quarter.	A.2.2.3 The patient safety manager develops reports on different safety/risk activities and disseminates them to all staff every quarter.
New		A.2.2.7 The patient safety manager develops and implements a process to improve the effectiveness of communication among all staff.
Reworded	A.2.3.1 The hospital regularly develops reports on different patient safety activities and disseminates them externally.	A.2.3.1 The patient safety manager develops reports on different safety/risk activities and disseminates them externally.
Reworded	A.3.2.1 The hospital sets and reviews targets related to patient safety goals.	A.3.2.1 The patient safety manager acts on measures and results through an action plan and patient safety improvement projects.
Reworded	A.3.2.2 The hospital has a set of process and output measures that assess performance with a special focus on patient safety.	A.3.2.2 The patient safety manager has a set of process and output measures that assesses performance with a special focus on patient safety.
Reworded and merged	A.3.3.1 The hospital compares its process and outcome patient safety indicator data over time, and/or with other patient safety friendly hospitals, and/or desirable known practices or standards. Merged with A.3.3.2	A.3.3.1 The hospital compares its patient safety indicator data over time, and/or with other patient safety friendly hospitals, and/or international best practices.
Merged	A.3.3.2 The hospital acts on benchmarking results through an action plan and patient safety improvement projects.	Merged with A.3.3.1

Changes	Second edition	Third edition
Reworded	A.4.1.1 The hospital ensures availability of essential functioning equipment.	A.4.1.1 The leadership ensures the availability of essential functioning equipment and supplies.
Reworded	A.4.2.1 The hospital undertakes regular preventive maintenance of equipment, including calibration.	A.4.2.1 There is a preventive maintenance programme to inspect, test and calibrate all equipment.
Reworded	A.4.2.2 The hospital undertakes regular repair or replacement of broken (malfunctioning) equipment.	A.4.2.2 There is a system in place to repair or replace broken (malfunctioning) equipment, including recalls or hazard notices.
Reworded	A.4.2.3 The hospital ensures that staff receive appropriate training for available equipment.	A.4.2.3 The hospital ensures that staff receive appropriate training for all essential equipment, including medical devices, and only trained and competent people handle specialized equipment.
Merged	A.4.3.1 The hospital trains relevant staff on appropriate and safe use of all infusion pumps.	Merged with A.4.2.3
Reworded	A.5 The hospital has technically competent staff for safer patients round the clock to deliver safe care.	A.5 The leadership ensures the provision of competent staff, including independent practitioners and volunteers, to deliver safe care at all times.
Reworded	A.5.1.1 Qualified clinical staff, both permanent and temporary, are registered to practise with an appropriate body.	A.5.1.2 There is a defined process to ensure all clinical staff are registered to practise with an appropriate body.
Reworded	A.5.2.1 Clinical staffing levels reflect patient needs at all times.	A.5.1.1 The leadership ensures the provision of sufficient numbers of competent staff to deliver safe patient care at all times. Upgraded to Critical criteria.
Merged	A.5.2.2 Sufficient, trained and appropriate non-clinical support staff are available to meet patient needs at all times.	Merged with A.5.1.1
Upgraded	A.5.3.1 The hospital has a workplace violence prevention programme.	A.5.2.2 The hospital has a workplace violence prevention programme. Upgraded to Core criteria.
New		A.6 The hospital has an information management system to support safe practices for all departments.
Reworded	A.6.2.1 The hospital has policies and procedures for all of its departments and services and has systems in place for monitoring their implementation.	A.6.2.1 There is a process to develop and control all documents, policies and procedures for all departments in a consistent controlled manner.
Reworded	B.1 Patient safety is incorporated into the patient and family rights statement for the hospital.	B.1 There is a programme to protect the rights of patients which includes patient safety.
Reworded	B.1.2.1 The hospital has a patient rights statement and it is visible to patients.	B.1.2.1 The hospital has a patient rights statement that is accessible to all patients, families and visitors.
Deleted	B.1.2.3 Patients and their families are briefed about, and aware of, their rights.	
New		B.1.2.3. There is a documented process to deal with situation if patients refuse treatment.

Changes	Second edition	Third edition
New		B.1.2.4 The hospital informs patients about their responsibilities while receiving care.
Deleted	B.1.3.1 Patient and community are involved in development of patient and family rights.	
Reworded	B.2.1.1 Informed consent is signed by the patient or authorized person. He/she is informed of all risks, benefits and potential side-effects of a procedure in advance. A physician explains, and a nurse oversees the signing.	B.2.1.1 Informed consent is obtained, before a procedure requiring informed consent, by trained staff in a manner and language the patient or authorized person can understand.
Reworded	B.2.2.1 The hospital builds health awareness for all of its patients and their families for their specific health problem and for general patient safety issues.	B.2.2.1 The hospital provides education that supports patient and family participation in care decisions and for general patient safety issues.
Reworded	B.2.2.3 The hospital trains patients' carers in post-discharge care.	B.2.2.3 The hospital trains patient and their carers in post-discharge care.
New		B.2.2.4 On admission, a full medical history, treatment plan and needs requirements are assessed and recorded in the patients' medical record. Core criteria.
New		B.2.2.5 On discharge, a detailed discharge/referral summary is shared with the patient and patient's primary physician. Core criteria.
New		B.2.2.6 Education methods take into account the patients' and families' cultures, values and preferences.
Reworded	B.2.3.2 The hospital has a health care website and patients have access to it.	B.2.3.2 The hospital provides patient safety advice through multiple mediums, including printed material, social media and on a publicly accessible website.
New		B.2.2.7 Patients are made aware and encouraged to use their voice in relation to the three WHO Global Patient Safety Challenges. Developmental criteria.
Reworded	B.3.1.1 The identification process used throughout the hospital requires at least two ways in which to identify a patient and these two identifiers are used in all locations within the hospital and in any circumstance involving patient interventions.	B.3.1.1 The identification process used throughout the hospital requires at least two ways in which to identify a patient.
Reworded	B.3.2.1 A system is in place to identify allergies.	B.3.2.1 A system is in place to identify and document allergies.
New		B.3.2.2 The patients' right to privacy and confidentiality of care and information are respected.
Reworded	B.3.3.1 The hospital uses bar coding with check digits for patient identification.	B.3.3.1 The hospital uses barcoding for patient identification.

Changes	Second edition	Third edition
Merged and reworded	B.4.2.2 The hospital plans events to promote patient safety through meetings on a regular basis with civic groups, nongovernmental organizations and community leaders. Merged with B.4.2.1	B.4.2.1 The hospital conducts patient safety campaigns that share solutions and raise awareness of patient safety in the community.
Reworded	B.5.3.1 The hospital has a structured system for disclosure to patients, their carers and staff.	B.5.2.1 The hospital has a policy on disclosure of incidents to staff, patients and their carers. Upgraded to Core criteria.
Reworded	B.5.3.2 The hospital has a health care mediator to explain incidents to patients and their carers.	B.5.2.2 The hospital has a patient advocacy service to explain, information received from the clinical team or incidents to patients and their carers. Upgraded to Core criteria.
Reworded	B.6 The hospital encourages patients to speak up and acts upon the patients' concerns.	B.6 The hospital encourages feedback from patients and acts upon the patients' concerns and compliments.
Reworded	B.6.2.1 The hospital obtains patients' and their carers' feedback through different tools.	B.6.2.1 The hospital obtains patients' and their carers' feedback through both reactive and proactive processes.
Reworded	B.6.2.2 The hospital responds to patients' complaints by sending them feedback on how each complaint was managed and changes that have taken place to prevent recurrence of the complaint.	B.6.2.2 There is a process for feedback (compliment or complaint or improvement) that includes how to receive, investigate and resolve in a defined time and the process is made available to patients, their family and the public.
Reworded	B.6.3.1 The hospital engages and empowers patients and/or patient safety advocacy associations in setting policies and suggesting quality improvement and patient safety projects.	B.6.3.1 The hospital involves patients and their carers in governance structures, developing policies and in implementing quality improvement and patient safety projects.
Merged	B.6.3.2 The hospital provides a chat/message board for patients and their carers to write their concerns and share successful solutions.	B.6.3.2 Merged with B.6.2.1
Deleted	B.7.2.1 The hospital staff are trained to be supportive and to deal with patients' anxieties.	B.7.2.1 The hospital provides patients with a private, confidential and a gender-friendly environment.
Reworded	B.7.2.2 The hospital has entertainment for patients.	B.7.2.2 The hospital provides space for social interaction, including entertainment for patients.
Deleted	B.7.2.4 The hospital staff support the patient's family in end-of-life cases.	
Reworded	C.1.1.1 The hospital maintains clear channels of communication for urgent critical results.	C.1.1.1 The hospital leadership maintains effective channels of communication throughout the hospital, including for urgent critical results.
Reworded	C.1.2.8 The hospital has systems in place for safe and thorough handover of patients between clinical teams (including shift staff).	C.1.1.5 The hospital has systems in place for safe and thorough handover of patients between clinical teams and between shifts. Upgraded to Critical criteria.
Reworded	C.1.2.9 The hospital implements safe childbirth guidelines, including WHO safe childbirth checklist.	C.1.1.6 The hospital implements safe childbirth guidelines and pathways of care. Upgraded to Critical criteria.

Changes	Second edition	Third edition
Reworded	C.1.2.6 The hospital maintains a list of approved abbreviations of medical terms and a list of dangerous abbreviations, symbols and dose designations that are prohibited for use in hospital.	C.1.2.6 The hospital maintains a list of approved abbreviations, symbols and dose designations for use in hospitals.
New		C.1.2.7 There is a process to integrate and coordinate the care provided to each patient within and between departments and with relevant external services.
Upgraded	C.1.2.7 The hospital minimizes use of verbal and telephone orders and transmission of results, and “read back” is practised where verbal communication is essential.	Upgraded to Critical criteria.
Reworded	C.1.2.1 The hospital conforms to clinical practice guidelines wherever appropriate, including WHO guidelines where available.	C.1.2.1 The hospital has a process to develop clinical guidelines and a local clinical guideline committee that meets regularly to select, develop and ensure implementation of guidelines, protocols and checklists relevant to safety.
Reworded	C.2.1.1 The hospital has an implemented infection prevention and control programme, including an organization scheme, guidelines, plan and manual.	C.2.1.1 The hospital has a coordinated programme for all infection prevention and control (IPC) activities that involves all disciplines.
Reworded	C.2.1.2 The hospital ensures proper cleaning, disinfection and sterilization of all equipment with a special emphasis on high-risk areas.	C.2.1.2 The hospital ensures proper cleaning, disinfection and sterilization of all equipment.
New		C.2.1.3 There is a qualified, designated person responsible for all infection prevention and control (IPC) activities. Critical criteria.
Reworded	C.2.2.1 The hospital conforms to recognized guidelines for infection prevention and control, including WHO guidelines.	C.2.2.1 The hospital conforms to evidence-based guidelines for infection prevention and control (IPC), including WHO multimodal improvement strategy for effective IPC programmes.
Moved	C.2.2.3 The hospital has a surveillance system for health care-associated infections.	C.2.3.1 The hospital has a surveillance system for hospital-acquired infections (HAIs).
Reworded	C.2.2.7 Staff are screened before employment and regularly afterwards for colonization and transmissible infections.	C.2.2.6 Staff are screened before employment and as best practice indicates, and afterwards for colonization and transmissible infections.
Reworded	C.3.1.1 The hospital implements guidelines, including WHO guidelines, on safe blood and blood products.	C.3.1.1 The hospital implements guidelines, including WHO guidelines, on safe quality blood and blood products.
Deleted and merged	C.3.1.2 The hospital has safe pre-transfusion procedures. Merged with C.3.2.1	C.3.1.2 The hospital ensures that patient blood samples for cross-matching are securely identified with two unique identifiers. Upgraded to Critical criteria.
Deleted	C.3.3.1 The hospital uses clinical practices that reduce blood loss and the need for blood transfusion. Covered in C.3.3.2	
Moved	C.4.2.1 The hospital has systems in place to ensure safe injection practice.	Moved to A.5.2.6

Changes	Second edition	Third edition
Reworded	C.5.2.1 The safe medication system of the hospital covers: selection and procurement; storage of medication; ordering and transcribing; preparing and dispensing; administration and follow-up.	C.4.1.1 A licenced pharmacist provides a medication management system that addresses patient needs, meets applicable regulations and adheres to WHO guidelines. Critical criteria.
Reworded	C.5.2.6 The hospital has a pain management system and controls access to narcotic products in inpatient departments.	C.4.2.5 The hospital complies with legislation on the use, access to and storage of narcotic and scheduled products.
Reworded	C.5.3.1 The hospital has clinical pharmacists that participate in medication orders and a system to identify drug–drug and drug–food interactions.	C.4.3.1 The hospital has clinical pharmacists who participate in medication orders and a system to identify drug and drug–food interactions.
Upgraded	C.5.3.2 The hospital has an implemented policy and procedure to manage medication errors.	Upgraded to Core criteria.
Moved	C.6.2.1 The hospital has and maintains a medical records archiving system.	Moved to A.6.2.2
Moved and merged	C.6.2.2 The hospital ensures that each patient has a single completed medical record with a unique identifier.	Moved to and merged with A.6.2.2
Moved and reworded	C.6.2.3 The hospital uses standardized codes for diseases (International Classification of Diseases, 10th Revision), diagnosis and procedures.	A.6.2.3 The hospital uses standardized codes for diseases diagnosis and procedures.
Moved and reworded	C.6.2.4 The hospital ensures that medical records are easily accessed by care providers whenever needed.	A.6.2.4 The hospital ensures that medical records are secure and easily accessed by care providers whenever needed.
Moved and reworded	C.6.3.1 Patients have access to their medical records with the opportunity to review and amend.	B.4.3.2 Patients have access to their medical records with the opportunity to seek clarification from the relevant medical practitioner.
Moved	C.6.3.2 The hospital has an automated information management and electronic medical records system with an appropriate backup system.	Moved to D.1.3.1
Deleted	C.6.3.3 The hospital has a computerized physician order entry.	
Deleted	C.6.3.4 The hospital has an automated clinical alarm system.	
Reworded	D.1.2.1 The hospital has a multidisciplinary environmental safety committee.	D.1.2.1 The hospital has a designated person in charge of environmental safety with the support of a multidisciplinary committee.
Reworded	D.1.2.2 The hospital design is maximized to provide a safe environment, including for infection control.	D.1.2.2 The hospital design is maximized to provide a safe environment, including for infection control and the segregation of clean and dirty spaces.
Reworded	D.1.2.3 The hospital has a preventive maintenance programme for its physical environment.	D.1.2.3 The hospital has a preventive maintenance programme for its medical equipment and the physical environment.
Reworded and merged	D.1.2.6 The hospital implements an external emergency plan. Merged with D.1.2.7	D.1.2.6 The hospital develops and tests plans for internal and external emergencies.

Changes	Second edition	Third edition
New		D.1.2.7 The hospital provides a monitoring system that alerts when critical services are at risk, such as electricity, water and medical gas-es. Core criteria.
Reworded	D.1.2.8 The hospital implements a fire and smoke safety programme with an evacuation plan.	D.1.2.8 The hospital implements a fire safety programme with an evacuation plan.
New		D.1.2.15 The hospital provides mechanisms to ensure a backup supply of essential services, including medical gases, water and electricity.
Reworded	D.1.2.9 The hospital has an effective utility system plan including water, medical gases, fuel, communication systems, pre-ventive maintenance, and a backup plan in case of failure or interruption.	D.1.2.9 The hospital has an effective utility system plan, including water, medical gases and fuel.
Reworded	D.1.2.10 The hospital has an implemented radiation safety programme.	D.1.2.10 The hospital has a radiation safety programme, including a designated responsible person.
Reworded	D.2.1.1 The hospital segregates waste according to hazard level (see guidelines) and colour codes it.	D.2.2.5 The hospital segregates waste according to hazard level and colour codes it.
Reworded	D.2.1.2 The hospital conforms to guidelines (including WHO guidelines) on management of sharps waste.	D.2.1.2 The hospital conforms to guidelines on management of sharps waste.
Reworded	D.2.2.1 The hospital conforms to guidelines (including WHO guidelines) on safe management of wastes from health care activities.	D.2.2.1 The hospital conforms to guidelines on safe waste management, including safe storage and disposal of waste.
Reworded	D.2.2.2 The hospital conforms to guidelines (including WHO guidelines) on management of biological waste.	D.2.2.2 The hospital conforms to guidelines on management of biological waste.
Reworded	D.2.2.3 The hospital conforms to guidelines (including WHO guidelines) on management of chemical waste.	D.2.2.3 The hospital conforms to guidelines on management of chemical waste.
Reworded	D.2.2.4 The hospital conforms to guidelines (including WHO guidelines) on management of radiological waste.	D.2.2.4 The hospital conforms to guidelines on management of radiological waste.
Upgraded	E.1.2.1 All hospital staff are provided with a patient safety orientation programme.	E.1.1.1 All hospital staff are provided with a patient safety orientation programme. Upgraded to Critical criteria.
Reworded	E.1.2.2 The hospital promotes on-going training for all staff to ensure safe patient care.	E.1.2.1 The hospital provides ongoing training and education for all staff to ensure safe patient care and staff respect patient rights.
Moved and reworded	E.1.3.1 All staff are familiar with the reporting procedures for near misses, adverse events and sentinel events, and steps to be taken during or after an adverse event.	Moved to A.2.2.5 and upgraded to Critical criteria.
New		E.2.3.2 The hospital conducts quality improvement projects to promote patient safety activities.

Changes	Second edition	Third edition
Moved and reworded	E.2.3.1 The medical staff committee or other committee monitors competency for all health care professionals.	Moved to A.5.2.1 and upgraded to Core criteria.
Moved and reworded	E.2.3.2 The hospital verifies the credentials of all health care professionals, including staff received from other national, regional and international institutions.	Moved and reworded to A.5.1.2 and upgraded to Critical criteria.
Merged and moved	E.3.2.1 The hospital conducts WHO cross-sectional studies to assess the magnitude and nature of adverse events to ensure safer care on a regular basis at least once every year.	Merged with E.3.3.1 and moved to E.2.3.1 The hospital conducts prospective, retrospective, and/or cross-sectional studies to assess the magnitude and nature of adverse events to improve the safety of care, on an annual basis.
Moved and reworded	E.3.3.2 The hospital has an implemented reporting system for adverse events, sentinel events and near misses.	Moved to A.2.2.5 Upgraded to Critical criteria.

▶ Section 2. Patient Safety Friendly Hospital Framework (PSFHF) standards

Section 2 includes a table of the standards for each of the five main domains, along with the number of critical, core and developmental criteria for each standard.

Each standard is detailed individually, with each of its criterion in a separate table, which also contains guidance on the key evidence of compliance documents for each criterion.

To assist in the implementation and evaluation process, more details on interviews, observations and a list of documents are found in Section 3.

Table 1. (previously mentioned): distribution of the criteria stratified by the PSFHF five domains

Domains (third edition)	Critical criteria	Core criteria	Developmental criteria	Total criteria in each domain
A. Leadership and management (6 standards: A1–A6)	7	26	3	36
B. Patient and public involvement (7 standards: B1–B7)	2	22	7	31
C. Safe evidence-based clinical practice (4 standards: C1–C4)	14	24	2	40
D. Safe environment (2 standards: D1–D2)	1	20	1	22
E. Lifelong learning (2 standards: E1–E2)	1	2	2	5
Total	25	94	15	134

Domain A: Leadership and management

Domain	Standard statement	Number of criteria		
		Critical	Core	Developmental
A. Leadership and management	A.1 The leadership and governance are committed to patient safety.	3	4	1
	A.2 The hospital has a patient safety programme.	1	7	1
	A.3 The hospital uses data to improve safety performance.	0	2	1
	A.4 The hospital has essential functioning equipment and supplies to deliver its services.	1	3	0
	A.5 The leadership ensures the provision of competent staff, including independent practitioners and volunteers, to deliver safe care at all times.	2	6	0
	A.6 The hospital has an information management system to support safe practices for all departments.	0	4	0
	Total	7	26	3

A.1	Criteria level	Criteria statement	Guidance for evidence of compliance
Leadership and governance are committed to patient safety	Critical criteria	A.1.1.1 The hospital has a strategic plan with patient safety as a priority.	<ul style="list-style-type: none"> Strategic plan with evidence of patient safety goals. Operational plan with evidence of annual patient safety activity.
		A.1.1.2 There is a recognized corporate and clinical governance/ leadership system within the hospital.	<ul style="list-style-type: none"> Organization chart that shows supervision/reporting relationships for all staff and all departments. Job descriptions of the chief executive officer (CEO) and medical director or equivalents
		A.1.1.3 The leadership promotes a culture of patient safety by conducting monthly patient safety walk-rounds to identify and take action on safety issues.	<ul style="list-style-type: none"> Schedule of executive walk-arounds. Members of walk-around teams. Minutes and actions taken. Feedback to staff.
	Core criteria	A.1.2.1 The leadership provides resources, including an annual budget for patient safety activities based on a detailed action plan.	<ul style="list-style-type: none"> Hospital budget showing designated line for patient safety. Financial resources for an IPC programme; staff training.
		A.1.2.2 The leadership provides a framework for ethical management that supports decision-making in clinical care and the management of research.	<ul style="list-style-type: none"> Code of ethics, e.g. in relation to research, resuscitation, consent and confidentiality. Policy on ethical support for difficult clinical decisions. Policy on research ethics.
		A.1.2.3 The leadership assesses patient safety culture on an annual basis with resulting action plans reviewed every three months.	<ul style="list-style-type: none"> Process to assess patient safety culture using a questionnaire, e.g. the Agency for Healthcare Research and Quality (AHRQ) questionnaire for the assessment of patient safety culture. Process to assess patient safety culture before and during patient safety programme implementation.
		A.1.2.4 Every year the leadership acknowledges and celebrates WHO Hand Hygiene Day (5 May) and World Patient Safety Day (17 September).	<ul style="list-style-type: none"> Evidence of patient safety activities in the hospital and/or in the community on 5 May and 17 September.
	Developmental criterion	A.1.3.1 The hospital's strategic plans have mission, vision and values statements that demonstrate a culture of patient safety.	<ul style="list-style-type: none"> Strategic plan with mission, vision and values statements. Evidence of patient safety within statements.

A.1.1.1 The hospital has a strategic plan with patient safety as a priority.

Measurable elements:

- Document demonstrating patient safety strategy and/or hospital strategy.
- Translating self-assessment and/or external assessment using the WHO *Patient safety assessment manual* findings into an action plan for improvement of patient safety.
- Patient safety action plan is detailed and has a monitoring strategy.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Document demonstrating the hospital's strategic plan for ensuring patient safety standards. • Monitoring reports for the plan's strategic objectives, including the risk of adverse events. • Action plan for overcoming the identified gaps based on the monitoring processes.
Interviews	<ul style="list-style-type: none"> • How does the strategic plan demonstrate patient safety? • How does the hospital assess its patient safety in relation to the <i>Patient safety assessment manual</i>? • How do you deal with the results of assessment reports? • How do you monitor and follow the implementation of actions taken?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has a strategic plan with patient safety as a priority, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital has no strategic plan with patient safety as a priority, score is not met.

A.1.1.2 There is a recognized corporate and clinical governance/leadership system within the hospital.**Measurable elements:**

- Organization chart that shows the hierarchy and reporting relationships of the clinical management team across all staff and all departments.
- Documents that show job descriptions of the chief executive officer (CEO) and medical director, or equivalents.
- Documents that show roles and responsibilities of the corporate and clinical governance team.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Organization chart that shows the hierarchy and reporting relationships of the corporate and clinical management team across all staff and all departments. • Documents that show job descriptions of the CEO and medical director, or equivalents. • Documents that show roles and responsibilities of the corporate and clinical governance team. • Internal or external assessment reports.
<p>Interviews</p>	<ul style="list-style-type: none"> • How does the hospital orient the management team about their roles and responsibilities? • Is reporting system active and in place? • How does the information flow through the structure? • Asking the relevant person, how is monitoring the effectiveness of clinical governance system operated within the hospital?
<p>Observation</p>	<ul style="list-style-type: none"> • Offices signs that show the offices of different management team members, such as directors, duty managers, on-duty clinicians, etc.

Scoring:

- If the hospital has a clear recognized corporate and clinical governance/leadership system, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital has no clear clinical leadership system, score is not met.

A.1.1.3 The leadership promotes a culture of patient safety by conducting monthly patient safety walk-rounds to identify and take action on safety issues.

Measurable elements:

- Reports of patient safety executive walk-rounds on a monthly basis.
- Evidence of patient safety executive walk-rounds to promote patient safety culture, learn about risks in the system and act on patient safety improvement opportunities.
- Improvements are made based on findings.
- Feedback sent to staff that suggests improvement or identifies an opportunity for improvement.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Stratified random samples of patient safety executive walk-round reports. • Stratified random samples of reports showing improvements are made based on findings of patient safety executive walk-rounds. • Stratified random samples of feedback letters/or emails to staff showing that their suggested improvements were taken into consideration and implemented.
Interviews	<ul style="list-style-type: none"> • Is there evidence of conducting patient safety executive walk-rounds?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the leadership conducts regular patient safety executive walk-rounds to promote patient safety culture, learn about risks in the system and acts upon patient safety improvement opportunities with reports and action plans for improvement, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the leadership has no evidence of regular patient safety executive walk-rounds to promote patient safety culture, learn about risks in the system and act upon patient safety improvement opportunities, score is not met.

A.1.2.1 The leadership provides resources, including an annual budget for patient safety activities based on a detailed action plan.

Measurable element:

- Resources are allocated for patient safety activities based on a detailed action plan.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Annual budget for patient safety activities based on a detailed action plan.
Interviews	<ul style="list-style-type: none"> • Is there evidence of assigned budget line for all patient safety action plans?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has an annual budget for patient safety activities based on a detailed action plan, score is fully met.
- If the hospital has an annual budget for some of its patient safety activities based on a detailed action plan, score is partially met.
- If the hospital does not have evidence of an annual budget for patient safety activities based on a detailed action plan, score is not met.

A.1.2.2 The leadership provides a framework for ethical management that supports decision-making in clinical care and the management of research.**Measurable elements:**

- Code of ethics, for example, in relation to research, resuscitation, consent and confidentiality.
- Process of monitoring compliance with the code of ethics.
- Policies and procedures for implementing the code of ethics.
- Training records of staff trained in policies and procedures for implementing the code of ethics.
- Ethical Committee meetings are held regularly.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Code of ethics, for example, in relation to research, resuscitation, consent and confidentiality. • Reports that include monitoring of compliance with code of ethics. • Policies and procedures for implementing the code of ethics. • Training records of staff trained in policies and procedures for implementing the code of ethics. • Reports of Ethical Committee meetings.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital follows a code of ethics, for example, in relation to research, resuscitation, consent and confidentiality, through regular ethics committee meeting reports and as evident in the hospital code of ethics?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital follows a code of ethics, as evidenced through regular ethics committee meeting reports and the existence of a hospital code of ethics, score is fully met.

- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not follow a code of ethics, as evidenced through regular ethics committee meeting reports and a hospital code of ethics is lacking, score is not met.

A.1.2.3 The leadership assesses patient safety culture on an annual basis with resulting action plans reviewed every three months.

Measurable elements:

- Process to assess patient safety culture using a questionnaire, for example, the Agency for Healthcare Research and Quality (AHRQ) questionnaire for the assessment of patient safety culture.
- Process to assess patient safety culture before and during patient safety programme implementation. It could be either assessed by safety attitudes and patient safety questionnaires or qualitative approaches.
- Performance data and quality improvement activities are reported to leadership every three months.
- Process to analyse data collected and implementation of an action plan for improvement.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Questionnaire to assess the culture of patient safety of staff. • Results of patient safety culture surveys and actions taken to-wards gathered data. • Reports about performance data and quality improvement ac-tivities to leadership.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the leadership assesses patient safety culture of staff on an annual basis?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the leadership assesses patient safety culture of staff on an annual basis, score is fully met.
- If the leadership assesses patient safety culture of staff irregularly, score is partially met.
- If the leadership does not assess patient safety culture of staff, score is not met.

A.1.2.4 Every year the leadership acknowledges and celebrates WHO Hand Hygiene Day (5 May) and World Patient Safety Day (17 September).

Measurable elements:

- The hospital is involved in the activities and the recognition of the World Hand Hygiene Day and the World Patient Safety Day; and the hospital ensures engagement of communities in the activities.
- The leadership is oriented about WHO hand hygiene guidelines and patient safety standards, and it recognizes the World Day of each, respectively.
- Celebrating and rewarding the hospital's champions in terms of ensuring and following WHO guidelines and standards for patient safety.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Documentation of the hospital's celebration and contributions for World Hand Hygiene Day and World Patient Safety Day, including reports, videos, photos and lectures. • List of honour (if applicable) for staff who demonstrate high performance in patient safety, including hand hygiene guidelines.
Interviews	<ul style="list-style-type: none"> • Are the clinical and management staff oriented about the World Hand Hygiene Day and World Patient Safety Day? • Is the management and leadership team prioritizing these challenges in their working agenda?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital annually acknowledges and celebrates the World Hand Hygiene Day and the World Patient Safety Day, score is fully met.
- If the hospital does not annually consider acknowledgment of the World Hand Hygiene Day and the World Patient Safety Day, score is partially met.
- If the hospital does not take part in any of these activities, score is not met.

A.1.3.1 The hospital's strategic plans have mission, vision and values statements that demonstrate a culture of patient safety.

Measurable elements:

- Document demonstrating the hospital's mission, vision and values in clear statements.
- Evidence of reflecting patient safety considerations in these statements.

Evaluation process:

- Review the documents listed for survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Documents demonstrating the hospital's mission, vision and values in clear statements. • Evidence of reflecting patient safety considerations in these statements.
Interviews	<ul style="list-style-type: none"> • Can the senior hospital's management spot patient safety considerations from the written statements of the hospital's mission, vision and values? • Are the hospital's staff aware of the hospital mission, vision and values, in addition to the aspect of patient safety on each?
Observation	<ul style="list-style-type: none"> • Noticing if there is a visually accessible board/sign mentioning the hospital mission, vision and values for everyone, including patients and visitors.

Scoring:

- If the hospital has clear strategic mission, vision and values that reflect patient safety consideration, score is fully met.
- If the hospital has partially met the measurable elements, score is partially met.
- If the hospital does not have any consideration for patient safety in their strategic plan, or does not have it at all, score is not met.

A.2	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has a patient safety programme	Critical criteria	A.2.1.1 The leadership ensures there is a designated qualified senior staff member with responsibility, accountability and authority for patient safety.	<ul style="list-style-type: none"> • Job description for patient safety coordinator or equivalent. • Organization structure.
	Core criteria	A.2.2.1 The hospital has a multidisciplinary patient safety internal body/committee to guide all safety and risk within the hospital.	<ul style="list-style-type: none"> • Terms of reference for the multidisciplinary body/committee for safety and risk. • Minutes of bi-monthly meetings.
		A.2.2.2 The patient safety programme has a schedule of quarterly audits and uses the results to improve patient services.	<ul style="list-style-type: none"> • Schedule of monthly audits, both clinical and environmental, including PSFHF assessment. • Improvements that are implemented based on findings.
		A.2.2.3 The patient safety manager develops reports on different safety/risk activities and disseminates them to all staff every quarter.	<ul style="list-style-type: none"> • Quarterly reports delivered to hospital staff and board. • Reports that include actions accomplished in patient safety action plan, statistics in relation to risk management programme.
		A.2.2.4 Patient safety-related risk is managed proactively.	<ul style="list-style-type: none"> • Procedure to focus on mitigating the risks of threats before these might occur. • Reporting system for near miss. • Audit schedule.
		A.2.2.5 A risk management framework, including a plan, policy and register, is used to identify and reduce adverse events and other safety risks to patients, visitors and staff.	<ul style="list-style-type: none"> • Risk management framework comprise of a plan, policy and register. • Adverse incident reporting and tracking system. • Risk register that includes a list of all risks that are prioritized, assigned responsibility and with a relevant mitigation plan.
		A.2.2.6 The hospital conducts bi-monthly morbidity and mortality (M&M) meetings.	<ul style="list-style-type: none"> • Terms of reference for the M&M committee. • Samples of case reviews and actions taken.
		A.2.2.7 The patient safety manager develops and implements a process to improve the effectiveness of communication among all staff.	<ul style="list-style-type: none"> • Communications strategy policies for: <ul style="list-style-type: none"> ○ clinical handover/SBAR ○ telephone orders ○ critical results.
	Developmental criterion	A.2.3.1 The patient safety manager develops reports on different safety/risk activities and disseminates them externally.	<ul style="list-style-type: none"> • Reports on different patient safety activities, disseminated externally to the Ministry of Health, WHO and/or patient safety organizations (whenever available at the national level) at least on an annual basis. • PSFHF survey reports benchmarked with other hospitals.

A.2.1.1 The leadership ensures there is a designated qualified senior staff member with responsibility, accountability and authority for patient safety.

Measurable elements:

- Terms of reference for the patient safety coordinator or equivalent.
- Notification letter for patient safety coordinator or equivalent.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Terms of reference for the patient safety coordinator or equivalent. • Notification letter for patient safety coordinator or equivalent.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of a designated person coordinating patient safety and risk management activities (middle management)?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If there is a designated qualified person who coordinates patient safety and risk management activities (middle management), score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If there is no designated person to coordinate patient safety and risk management activities (middle management), score is not met.

A.2.2.1 The hospital has a multidisciplinary patient safety internal body/committee to guide all safety and risk within the hospital.

Measurable elements:

- Terms of reference for the multidisciplinary patient safety internal body/committee or equivalent.
- Minutes of the meeting of the multidisciplinary patient safety internal body/committee or equivalent.
- Notification letter for multidisciplinary patient safety internal body/committee.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Terms of reference for the multidisciplinary patient safety internal body/committee or equivalent. • Minutes of meetings of the multidisciplinary patient safety internal body/committee or equivalent. • Notification letter for multidisciplinary patient safety internal body/committee.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has a multi-disciplinary patient safety internal body or any other committee, whose members meet regularly to ensure an overarching patient safety programme?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has a multidisciplinary patient safety internal body or any other committee, whose members meet regularly to ensure an overarching patient safety programme, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a multidisciplinary patient safety internal body or any other committee, whose members meet regularly to ensure an overarching patient safety programme, score is not met.

A.2.2.2 The patient safety programme has a schedule of quarterly audits and uses the results to improve patient services.

Measurable elements:

- Patient safety audit using the WHO *Patient safety assessment manual* on a quarterly basis.
- Process to assess safety practices before and during patient safety programme implementation.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Schedule of patient safety programme for quarterly audits. • Patient safety audit reports. • Action taken on the audit reports.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital audits its safe-ty practices on a regular basis?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital audits its safety practices on a quarterly basis, score is fully met.
- If the hospital audits its safety practices on an irregular basis, score is partially met.
- If the hospital does not audit its safety practices on a quarterly basis, score is not met.

A.2.2.3 The patient safety manager develops reports on different safety/risk activities and disseminates them to all staff every quarter.**Measurable elements:**

- Quarterly reports delivered to the hospital board.
- Reports that include actions accomplished in patient safety action plan, bottlenecks faced, new patient safety issues that need to be addressed, statistics on frequency of iatrogenic harm and lessons learned.
- Staff access to patient safety reports.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Reports on different patient safety activities.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital regularly develops reports on different patient safety activities and disseminates them internally every quarter?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital regularly develops reports on different patient safety activities and disseminates them internally, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not develop reports on different patient safety, score is not met.

A.2.2.4 Patient safety-related risk is managed proactively.**Measurable elements:**

- Risk register.
- At least one failure mode and effect analysis (FMEA) that has been carried once a year.
- The team may consider “never events” to be included for the proactive assessment of the risk. Never events are "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability". These include a list of serious medical errors or adverse events (e.g.

wrong-site surgery or hospital-acquired pressure ulcers) that should never happen to a patient.

- Improvements that are implemented based on findings.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Reports of proactive patient safety improvement projects, e.g. addressing patient safety international goals. • Explicit documents with specific focus on never events. • FMEA documents mentioning the proactive study of potential patient incidents. • Report that shows subsequent corrective measures that were directed towards preventing risk proactively.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of proactive patient safety im-provement projects?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If risk is managed proactively using failure mode and effect analysis or other proactive tools at least once a year, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If risk is not managed proactively, score is not met.

A.2.2.5 A risk management framework, including a plan, policy and register, is used to identify and reduce adverse events and other safety risks to patients, visitors and staff.

Measurable elements:

- Risk management framework (plan, policy and register) is used within the hospital.
- In-place adverse incident reporting system.
- Designated person who is mainly responsible to coordinate the implementation and monitoring of the risk management plans and policies.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Documents that show details of the hospital's risk management policies and plans. • Reports about adverse events that illustrate a recognized reporting system for adverse event incidences. • Job description/duties for a designated person who is responsible for applying the risk management plans.
Interviews	<ul style="list-style-type: none"> • Relevant staff: What are the risk management policies and strategies that are followed in the hospital? • Relevant staff: How do you monitor the progress of implementing the risk management plans to overcome the identified challenges?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has clear risk management plan and policies, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not consider any risk management plans or policies, score is not met.

A.2.2.6 The hospital conducts bi-monthly morbidity and mortality (M&M) meetings.

Measurable elements:

- Morbidity and mortality committee or equivalent terms of reference.
- Morbidity and mortality committee or equivalent minutes of meetings.
- Meetings are regular and at least on bi-monthly basis.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Morbidity and mortality committee or equivalent terms of reference. • Morbidity and mortality committee designated letter. • Morbidity and mortality committee or equivalent minutes of meetings, to check at least three consecutive meetings.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conducts regular monthly morbidity and mortality meetings?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital conducts regular bi-monthly morbidity and mortality meetings, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conduct regular monthly morbidity and mortality meetings, score is not met.

A.2.2.7 The patient safety manager develops and implements a process to improve the effectiveness of communication among all staff.

Measurable elements:

- The hospital has an effective communication system in place.
- Quality of the forms used for a clinical handover and referral system, including the SBAR strategy (Situation, Background, Assessment, and Recommendation).
- Referral system of critical results.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Documents that explain the hospital's communication strategy and reporting system. • Referral forms of clinical cases for handover and between departments and externally to different hospitals. • Referral forms/policies of critical and urgent results.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there an effective communication strategy between clinical staff for referring patients? • Relevant staff: Is there a well-established strategy to deal with critical clinical results and urgent cases?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has an implemented strategic plan to improve the effectiveness of communication among all staff, score is met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not work on maintaining/improving effective communication channels among all staff, score is not met.

A.2.3.1 The patient safety manager develops reports on different safety/risk activities and disseminates them externally.

Measurable elements:

- Reports on different patient safety activities, disseminated externally to the Ministry of Health, WHO and/or patient safety organizations (whenever available at the national level) at least on annual basis.
- Reports that may include actions accomplished in patient safety action plan, bottlenecks faced, new patient safety issues that need to be addressed, and statistics on frequency of iatrogenic harm, and communicate lessons learned.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Reports on different patient safety activities, disseminated externally to the Ministry of Health, WHO and/or patient safety organizations.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital regularly develops reports on different patient safety activities and disseminates them externally?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital regularly develops reports on different patient safety activities and disseminates them externally, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not develop reports on different patient safety activities, score is not met.

A.3	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital uses data to improve safety performance	Core criteria	A.3.2.1 The patient safety manager acts on measures and results through an action plan and patient safety improvement projects.	Action plan/quality improvement plans for patient safety programme.
		A.3.2.2 The patient safety manager has a set of process and output measures that assesses performance with a special focus on patient safety.	<ul style="list-style-type: none"> • Patient safety goals. • Patient safety indicators profile. • Targets related to patient safety goals. • Key performance indicators (KPIs).
	Developmental criterion	A.3.3.1 The hospital compares its patient safety indicator data over time, and/or with other patient safety friendly hospitals, and/or international best practices.	Reports of benchmark data over time showing correlation to best international practice and/or other PSFHF participants.

A.3.2.1 The patient safety manager acts on measures and results through an action plan and patient safety improvement projects.

Measurable elements:

- Action plan based on benchmarking results.
- Patient safety improvement projects.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Benchmarking results. • Action plan and patient safety improvement projects reports. • Lessons learned reports/emails.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of the hospital acting on benchmarking results through an action plan and patient safety improvement projects?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital acts on benchmarking results through an action plan and patient safety improvement projects, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not act on benchmarking, score is not met.

A.3.2.2 The patient safety manager has a set of process and output measures that assesses performance with a special focus on patient safety.

Measurable element:

- Performance measurement reports.

Evaluation process:

- Review set of processes and output measures for patient safety.
- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Performance measurement reports. • Patient safety indicators profile.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence the hospital has a set of process and output measures that assesses performance with a special focus on patient safety?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has a set of process and output measures that assesses performance with a special focus on patient safety, and there is evidence of performance assessment, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a set of process and output measures that assesses performance with a special focus on patient safety, score is not met.

A.3.3.1 The hospital compares its patient safety indicator data over time, and/or with other patient safety friendly hospitals, and/or international best practices.

Measurable elements:

- Process by which the hospital compares its process and outcome patient safety indicators data over time (e.g. before and after implementation of a safety improvement programme), with other patient safety friendly hospitals, and with desirable known practices (e.g. zero rate of ventilator-acquired pneumonia) and standards (e.g. WHO hand hygiene guidelines).
- Benchmark reports.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> List of selected patient safety indicators and corresponding metadata. Training records of staff on the collection of data.
Interviews	<ul style="list-style-type: none"> Relevant staff: Is there evidence that the hospital compares its process and outcome indicator data with those of other patient safety friendly hospitals?
Observation	<ul style="list-style-type: none"> Data over time and trends, benchmark reports and comparison with other facilities.

Scoring:

- If the hospital compares its process and outcome indicator data with other patient safety friendly hospitals, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not compare its process and outcome indicator data with other patient safety friendly hospitals, score is not met.

A.4	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has essential functioning equipment and supplies to deliver its services	Critical criterion	A.4.1.1 The leadership ensures the availability of essential functioning equipment and supplies in each department.	<ul style="list-style-type: none"> • Process to identify what essential equipment and supplies are required according to the patient services offered. • Asset register for all equipment. • Availability of resuscitation equipment.
	Core criteria	A.4.2.1 There is a preventive maintenance programme to inspect, test and calibrate all equipment.	<ul style="list-style-type: none"> • Documented preventive maintenance programme with designated responsible person. • Procedures for preventive maintenance for equipment, including calibration tests. • Schedule for routine tests and calibration of machines. • Preventive equipment maintenance reports.
		A.4.2.2 There is a system in place to repair or replace broken (malfunctioning) equipment, including recalls or hazard notices.	<ul style="list-style-type: none"> • Procedures to replace equipment. • Policy to communicate hazard notices to the relevant staff.
		A.4.2.3 The hospital ensures that staff receive appropriate training for all essential equipment, including medical devices, and only trained and competent people handle specialized equipment.	Training logs to include use of and maintenance of: <ul style="list-style-type: none"> ○ infusion pumps ○ resuscitation equipment ○ medical devices ○ lifesaving machines.

A.4.1.1 The leadership ensures the availability of essential functioning equipment and supplies.

Measurable elements:

- Process to identify and maintain essential functioning equipment according to services offered and patient needs.
- Availability of resuscitation equipment for basic and advanced life support and distribution according to patient needs.
- Process to evaluate whether equipment is functioning on an ongoing basis.
- Process to measure availability of and compliance with essential functioning equipment standards.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Lists of essential functioning equipment. • Reports that include measurement of availability of and compliance with essential functioning equipment standards.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital ensures availability of essential functioning equipment?
Observation	<ul style="list-style-type: none"> • Essential functioning equipment.

Scoring:

- If the hospital monitors availability of essential equipment for all of its departments, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure availability of essential equipment for any of its departments, score is not met.

A.4.2.1 There is a preventive maintenance programme to inspect, test and calibrate all equipment.

Measurable elements:

- Preventive equipment maintenance reports.
- Relevant preventive maintenance for equipment, including calibration policies and procedures.
- Training records of staff trained in policies and procedures for preventive maintenance of equipment, including calibration.
- Process to measure compliance with policies and procedures for preventive maintenance of equipment, including calibration.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Preventive equipment maintenance reports/records. • Policies and procedures for preventive equipment maintenance. • Training records of staff trained in policies and procedures for preventive equipment maintenance. • Reports that include measuring compliance with policies and procedures for preventive equipment maintenance.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital undertakes regular preventive maintenance of equipment, including calibration?
Observation	<ul style="list-style-type: none"> • Compliance with policies and procedures for preventive maintenance of equipment, including calibration.

Scoring:

- If the hospital undertakes regular preventive maintenance of equipment, including calibration, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not undertake any preventive maintenance of equipment, including calibration, score is not met.

A.4.2.2 There is a system in place to repair or replace broken (malfunctioning) equipment, including recalls or hazard notices.**Measurable elements:**

- Policies and procedures for corrective equipment maintenance.
- Training records of staff trained in policies and procedures for corrective equipment maintenance.
- Process to measure compliance with policies and procedures for corrective equipment maintenance.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for corrective equipment maintenance. • Training records of staff trained in policies and procedures for corrective equipment maintenance. • Reports that include measuring compliance with policies and procedures for corrective equipment maintenance. • Corrective equipment maintenance records.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital undertakes regular repair or replacement of broken (malfunctioning) equipment?
Observation	<ul style="list-style-type: none"> • Compliance with policies and procedures for corrective equipment maintenance. • Broken (malfunctioning) equipment.

Scoring:

- If the hospital undertakes regular repair or replacement of broken (malfunctioning) equipment, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not provide a mechanism for repair or replacement of malfunctioning equipment, score is not met.

A.4.2.3 The hospital ensures that staff receive appropriate training for all essential equipment, including medical devices, and only trained and competent people handle specialized equipment.

Measurable elements:

- Process to ensure staff receive appropriate training for existing and new equipment.
- Training records of staff trained in existing and new equipment.
- Records that show only trained and competent people handle specialized equipment.
- Training logs to include use of infusion pumps and resuscitation equipment
- Process to measure compliance with and staff receive appropriate training for existing and new equipment standards.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Training records of staff trained in relevant policies and procedures. • Reports that include measuring compliance with policies and whether staff receive appropriate training for existing and new equipment standards. • Records that show only trained and competent people handle specialized equipment
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital ensures that staff receive appropriate training for available equipment?
Observation	<ul style="list-style-type: none"> • Not applicable

Scoring:

- If the hospital ensures staff receive appropriate training for available equipment, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure staff receive appropriate training for available equipment, score is not met.

A.5	Criteria level	Criteria statement	Guidance for evidence of compliance
The leadership ensures the provision of competent staff, including independent practitioners and volunteers, to deliver safe care at all times	Critical criteria	A.5.1.1 The leadership ensures the provision of sufficient numbers of competent staff to deliver safe patient care at all times.	<ul style="list-style-type: none"> • Human Resources (HR) plan. • Designated person responsible for HR planning.
		A.5.1.2 There is a defined process to ensure all clinical staff are registered to practise with an appropriate body.	<ul style="list-style-type: none"> • Policies for validating and recording staff qualifications and licences, including designated responsible person. • Personnel files with evidence of staff qualifications, professional registrations and licences (registration to practise with an appropriate body).
	Core criteria	A.5.2.1 There is a system in place to monitor the ongoing competency levels for all health care staff, including independent practitioners and volunteers.	<ul style="list-style-type: none"> • Evidence-based, structured process to monitor competency for all health care professionals, based on qualifications and experience, to provide clinical and technical services and procedures. • Terms of reference for medical staff or other relevant committees. • Minutes of medical staff committee meetings.
		A.5.2.2 The hospital has a workplace violence prevention programme.	Workplace violence prevention programme.
		A.5.2.3 Staff are allowed sufficient rest breaks to practise safely and adhere to national labour laws.	<ul style="list-style-type: none"> • Policies and procedures for the clinical staffing level. • Duty rosters for clinical staff. • Compliance with national labour laws and regulations. • Policies and procedures for sufficient rest breaks to practise safely.
		A.5.2.4 Students and trainees work within their competencies and under appropriate supervision.	Policies and procedures for students and trainees to work within their competencies and under appropriate supervision.
		A.5.2.5 An occupational health programme is implemented for all staff.	<ul style="list-style-type: none"> • Occupational health programme, including: <ul style="list-style-type: none"> ○ training for manual handling ○ work place assessments ○ mental health supports. • Personnel records with evidence of occupational health records.
		A.5.2.6 The hospital has systems in place to ensure safe injection practice.	<ul style="list-style-type: none"> • Policies for: <ul style="list-style-type: none"> ○ sharps management ○ management of needle stick injury ○ safe injection policies and procedures that include preventing reuse of needles, educating patients and families regarding transmission of bloodborne pathogens and ensuring safe disposal practices for sharp items, e.g. no recapping of needles, and safety boxes for sharps ○ implementation guidelines for ultrasonography assisted central line placement.

A.5.1.1 The leadership ensures the provision of sufficient numbers of competent staff to deliver safe patient care at all times.

Measurable elements:

- Duty rosters for clinical staff.
- Policies and procedures for clinical staffing levels.
- Training records of staff trained in policies and procedures for clinical staffing levels.
- Process to measure compliance with policies and procedures for clinical staffing levels.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Duty rosters for clinical staff. • Policies and procedures for clinical staffing levels. • Training records of staff trained in policies and procedures for clinical staffing levels. • Reports that include measuring compliance with policies and procedures for clinical staffing levels.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of clinical staffing levels reflecting patient needs at all times?
Observation	<ul style="list-style-type: none"> • Implemented measures to ensure appropriate clinical staffing levels.

Scoring:

- If clinical staffing levels reflect patient needs at all times, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If clinical staffing levels do not reflect patient needs, score is not met.

A.5.1.2 There is a defined process to ensure all clinical staff are registered to practise with an appropriate body.

Measurable elements:

- Staff qualifications and licences (registration to practise within an appropriate body).
- Policies and procedures for staff qualifications and licences.
- Training records of staff trained in policies and procedures for staff qualifications and licences.
- Process to measure compliance with policies and procedures for staff qualifications and licences.
- Personnel files with evidence of orientation to the staff qualifications and licences

(registration to practise within appropriate body).

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for staff qualifications and licences. • Training records of staff trained in policies and procedures for staff qualifications and licences. • Reports that include measuring compliance with policies and procedures for staff qualifications and licences. • Personnel files with evidence of staff qualifications and licences (registration to practise within appropriate body).
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of qualified clinical staff, both permanent and temporary, being registered to practise with an appropriate body?
Observation	<ul style="list-style-type: none"> • Random selection of several records.

Scoring:

- If qualified clinical staff, both permanent and temporary, are registered to practise with an appropriate body, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If qualified clinical staff are not registered to practise with an appropriate body, score is not met.

A.5.2.1 There is a system in place to monitor the ongoing competency levels for all health care staff, including independent practitioners and volunteers.

Measurable elements:

- Terms of reference for medical staff or other committee.
- Minutes of medical staff committee meetings.
- Evidence-based, structured process to monitor competency for all health care professionals, based on qualifications and experience, to provide clinical services and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.

- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Terms of reference for medical or other committees. • Minutes of medical staff or other committee meetings.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the medical staff committee monitors competency for all health care professionals?
Observation	<ul style="list-style-type: none"> • Random sample of medical staff personnel files to review qualifications and experience and approved procedures and services.

Scoring:

- If the medical staff committee monitors competency for 80–100% of health care professionals, score is fully met.
- If the medical staff committee monitors competency for 60–79% of health care professionals, score is partially met.
- If the medical staff committee monitors competency for <60% of health care professionals, score is not met.

A.5.2.2 The hospital has a workplace violence prevention programme.

Measurable elements:

- Workplace violence prevention programme policies and procedures.
- Training records of staff trained in workplace violence prevention programme policies and procedures.
- Process to measure compliance with workplace violence prevention programme policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Workplace violence prevention programme policies and procedures. • Training records of staff trained in workplace violence prevention programme policies and procedures. • Reports that include measuring compliance with workplace violence prevention programme policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has a workplace violence prevention programme?

Observation	<ul style="list-style-type: none"> • Not applicable.
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Scoring:

- If the hospital has a workplace violence prevention programme, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a workplace violence prevention programme, score is not met.

A.5.2.3 Staff are allowed sufficient rest breaks to practise safely and adhere to national labour laws.**Measurable elements:**

- Compliance with national labour laws and regulations.
- Policies and procedures for sufficient rest breaks to practise safely.
- Training records of staff trained in policies and procedures for sufficient rest breaks to practice safely.
- Process to measure compliance with policies and procedures for sufficient rest breaks to practise safely.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for sufficient rest breaks to practise safely. • Training records of staff trained in policies and procedures for sufficient rest breaks to practise safely. • Reports that include measuring compliance with policies and procedures for sufficient rest breaks to practise safely.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that staff are allowed sufficient rest breaks to practise safely and adhere to national labour laws?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If all staff are allowed sufficient rest breaks to practise safely and adhere to national labour laws, score is fully met.

- If the hospital has partial compliance with measurable elements, score is partially met.
- If staff are generally not allowed sufficient rest breaks to practise safely and adhere to national labour laws, score is not met.

A.5.2.4 Students and trainees work within their competencies and under appropriate supervision.

Measurable elements:

- Policies and procedures for students and trainees to work within their competencies and under appropriate supervision.
- Training records of staff trained in policies and procedures for students and trainees to work within their competencies and under appropriate supervision.
- Process to measure compliance with policies and procedures for students and trainees to work within their competencies and under appropriate supervision.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for students and trainees to work within their competencies and under appropriate supervision. • Training records of students and trainees trained in policies and procedures to work within their competencies and under appropriate supervision. • Reports that include measuring compliance of students and trainees with policies and procedures to work within their competencies and under appropriate supervision.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of students and trainees working within their competencies and under appropriate supervision?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If students and trainees work within their competencies and under appropriate supervision, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If students and trainees work within their competencies, but not under appropriate supervision, score is not met.

A.5.2.5 An occupational health programme is implemented for all staff.

Measurable elements:

- Occupational health records for all staff.
- Occupational health programme policies and procedures.

- Training records of staff trained in occupational health programme policies and procedures.
- Process to measure compliance with occupational health programme policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Occupational health records for all staff. • Occupational health policies and procedures. • Training records of staff trained in occupational health policies and procedures. • Reports that include measuring compliance with occupational health policies and procedures. • Policies on safe injection practices.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of an occupational health programme that is implemented for all staff?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If there is an occupational health programme that is implemented for all staff, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If there is no occupational health programme being implemented for staff, score is not met.

A.5.2.6 The hospital has systems in place to ensure safe injection practice.

Measurable elements:

- Safe injection policies and procedures that include preventing reuse of needles at the hospital, educating patients and families regarding transmission of bloodborne pathogens and ensuring safe disposal practices for sharp items, e.g. no recapping of needles and safety boxes for sharps.
- Training records of staff trained in safe injection policies and procedures.
- Process to measure compliance with safe injection policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Safe injection policies and procedures. • Training records of staff trained in safe injection policies and procedures. • Reports that measure compliance with safe injection policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of systems in place to ensure safe injection?
Observation	<ul style="list-style-type: none"> • No re-capping of needles, and safety boxes for sharps.

Scoring:

- If the hospital has systems in place to ensure and monitors safe injection practice score is fully met;
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have systems in place to ensure safe injection practice, score is not met.

A.6	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has an information management system to support safe practices for all departments	Core criteria	A.6.2.1 There is a process to develop and control all documents, policies and procedures for all departments in a consistent controlled manner.	<ul style="list-style-type: none"> ● Policy for development of policies. ● Template for uniform policies. ● Documentation/records control system.
		A.6.2.2. The hospital maintains a standardized medical record with a unique identifier for every patient.	Polices on: <ul style="list-style-type: none"> ○ content of medical record ○ generating unique patient identifier ○ validating patient identification. Audit of: <ul style="list-style-type: none"> ○ completeness of medical records ○ legibility of hand writing.
		A.6.2.3. The hospital uses standardized codes for diseases diagnosis and procedures.	Reports using the International Classification of Diseases (ICD), 10th or 11th edition.
		A.6.2.4 The hospital ensures that medical records are secure and easily accessed by care providers whenever needed.	Audit on availability of medical records.

A.6.2.1 There is a process to develop and control all documents, policies and procedures for all departments in a consistent controlled manner.

Measurable elements:

- Policies and procedures for all the departments and services.
- Training records of staff trained in relevant policies and procedures.
- Process to measure compliance with relevant policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Policies and procedures for all departments and services. • Training records of staff trained in departmental and/or services policies and procedures. • Reports that include measuring compliance with departmental and/or services policies and procedures • Template for uniform policies. • Documentation control system. • Policies at a minimum to include: <ul style="list-style-type: none"> ○ security and staff identification ○ client identification ○ client privacy and confidentiality ○ complaints ○ adverse incident reporting ○ reporting accidents, suspicious behaviour to the police ○ designated areas for smoking ○ information to clients on fee structure ○ infection control and hand hygiene ○ informed consent ○ approved list of abbreviations ○ medication safety ○ preventative maintenance.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has policies and procedures for its departments and services and has systems in place for monitoring their implementation?
<p>Observation</p>	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has policies and procedures for 80–100% of departments and services and has systems in place for monitoring their implementation, score is fully met.
- If the hospital has policies and procedures for 60–79% of its departments and services, score is partially met.
- If the hospital does not have policies and procedures or a system in place for monitoring their implementation, or has a system in place for <60% of departments and services, score is not met.

A.6.2.2. The hospital maintains a standardized medical record with a unique identifier for every patient.

Measurable elements:

- Process to ensure that each patient has a single completed medical record with a unique identifier.
- Policies and procedures for single completed medical records.
- Training records of staff trained in policies and procedures for single completed medical records.
- Process to measure compliance with policies and procedures for single completed medical records.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for single completed medical records. • Training records of staff trained in policies and procedures for single completed medical records. • Reports that include measuring compliance with policies and procedures for single completed medical records.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital ensures that each patient has a single completed medical record with a unique identifier?
Observation	<ul style="list-style-type: none"> • Single completed medical records with unique identifiers.

Scoring:

- If each patient has a single completed medical record with a unique identifier, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If each patient does not have a single completed medical record with a unique identifier, score is not met.

A.6.2.3. The hospital uses standardized codes for diseases diagnosis and procedures.

Measurable elements:

- Process to use standardized codes for diseases (International Classification of Diseases [ICD], 10th or 11th edition), diagnosis and procedures.
- Standardized codes for diseases (ICD-10, ICD-11), diagnosis and procedures.
- Policies and procedures for standardized codes for diseases.
- Training records of staff trained in policies and procedures for standardized codes for diseases.
- Process to measure compliance with policies and procedures for standardized codes for diseases.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for standardized codes for diseases. • Training records of staff trained in policies and procedures for standardized codes for diseases. • Reports that include measuring compliance with policies and procedures for relevant standardized codes for diseases.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital uses standardized codes for diseases (ICD-10, ICD-11), diagnosis and procedures?
Observation	<ul style="list-style-type: none"> • Standardized codes for diseases (ICD-10, ICD-11), diagnosis and procedures.

Scoring:

- If the hospital uses standardized codes for diseases (ICD-10, ICD-11), diagnosis and procedures, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not use standardized codes for diseases (ICD-10, ICD-11), diagnosis and procedures, score is not met.

A.6.2.4 The hospital ensures that medical records are secure and easily accessed by care providers whenever needed.**Measurable elements:**

- Medical records access policies and procedures.
- Training records of staff trained in medical records access policies and procedures.
- Process to measure compliance with medical records access policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Medical records access policies and procedures. • Training records of staff trained in medical records access policies and procedures. • Reports that include measuring compliance with medical records access policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of medical records being easily accessed by care providers whenever needed?
Observation	<ul style="list-style-type: none"> • Any measures implemented to secure medical records and to ensure easy access to care providers.

Scoring:

- If medical records are easily accessed by care providers whenever needed, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If medical records are not easily accessed by care providers whenever needed, score is not met.

Domain B: Patient and public involvement

Domain	Standard statement	Number of criteria		
		Critical	Core	Developmental
B. Patient and public involvement standards	B.1 There is a programme to protect the rights of patients that includes patient safety.	0	4	0
	B.2 The hospital builds health awareness for its patients and carers to empower them to share in making the right decisions regarding their care.	1	7	2
	B.3 The hospital ensures proper patient identification and verification at all stages of care.	1	2	1
	B.4 The hospital involves the community in different patient safety activities.	0	2	2
	B.5 The hospital communicates patient safety incidents to patients and their carers.	0	2	0
	B.6 The hospital encourages feedback from patients and acts upon the patients' concerns and compliments.	0	2	2
	B.7 The hospital has a patient safety friendly environment.	0	3	0
	Total	2	22	7

B.1	Criteria level	Criteria statement	Guidance for evidence of compliance
There is a programme to protect the rights of the patient which includes patient safety	Core criteria	B.1.2.1 The hospital has a patient rights statement that is accessible to all patient, families and visitors.	Patient rights statement that is: <ul style="list-style-type: none"> ○ documented and approved ○ is visible to patients and carers throughout the hospital ○ is supported by policies and procedures.
		B.1.2.2 Patient safety is included in the patient rights statement.	Evidence of how patient safety is included in the patient rights statement, i.e. patients have the right to: <ul style="list-style-type: none"> ○ a safe, secure and clean environment ○ competent staff.
		B.1.2.3 There is a documented process to deal with situation if patients refuse treatment.	Policy and form for patients who refuse treatment against medical advice.
		B.1.2.4 The hospital informs patients about their responsibilities while receiving care.	<ul style="list-style-type: none"> ● Patient responsibility statement that is: <ul style="list-style-type: none"> ○ documented and approved ○ visible to patients and carers throughout the hospital. ● Responsibilities could include providing accurate information to care providers, facilitating the delivery of care and respecting the rights of staff.

B.1.2.1 The hospital has a patient rights statement that is accessible to all patients, families and visitors.

Measurable elements:

- Written and approved patient and family rights statement.
- Patient and family rights statement is visible to patients and carers throughout the hospital.
- Patient and family rights are communicated to them upon request.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Written and approved patient and family rights statement. • A process for communication of patient and family rights upon request.
Interviews	<ul style="list-style-type: none"> • Who approves the patient rights statement? • Does the patient and family rights comply with national law?
Observation	<ul style="list-style-type: none"> • The hospital has a patient rights statement and it is visible to patients.

Scoring:

- If there is a patient rights statement in the hospital and it is visible to patients, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If there is no patient rights statement in the hospital, score is not met.

B.1.2.2 Patient safety is included in the patient rights statement.**Measurable elements:**

- Written and approved patient and family rights statement in which patient safety is incorporated, which includes, but is not limited to:
 - o right to access care in the hospital
 - o right to respect patients' cultural and spiritual beliefs and personal preferences
 - o right to be informed and involved in taking in all medical decisions during their care
 - o right to complain
 - o right to patient safety
 - o right to security, privacy and confidentiality
 - o right to have pain managed
 - o right to access information about hospital services and outcomes
 - o right to refuse treatment.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Written and approved patient and family rights statement in which patient safety is incorporated. • Patient safety rights policies and procedures
Interviews	<ul style="list-style-type: none"> • What are patient rights?
Observation	<ul style="list-style-type: none"> • The patient and family rights statement is visible throughout the hospital.

Scoring:

- If there is a patient rights statement and patient safety is included in the patient rights statement, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If there is no patient rights statement and patient safety is not included in the patient rights statement, score is not met.

B.1.2.3 There is a documented process to deal with the situation if patients refuse treatment.

Measurable elements:

- The hospital's policy for patients who refuse treatment following the recommended medical management and treatment.
- Documentation of cases that refuse treatment and the causes behind those decisions.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Forms and consent taken from patients who refuse to follow the medical team's recommendations and prescribed treatment • Documents that show the hospital's policy for those who refuse to take recommended prescriptions.
Interviews	<ul style="list-style-type: none"> • Medical professional: How does the medical professional deal with patients who refuse to take treatment against the recommended medical advice?
Observation	<ul style="list-style-type: none"> • The hospital has a patient rights statement, including the patient's right to refuse taking treatment, and it is visible to patients

Scoring:

- If the hospital has a clear policy to be applied for patients who refuse to take treatment, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital has no well-established policy to deal with patients who refuse to take treatment or follow the medical advice, score is not met.

B.1.2.4 The hospital informs patients about their responsibilities while receiving care.

Measurable elements:

- Written and approved patient and family responsibilities statement.
- Patient and family responsibilities statement is visible to patients and carers throughout the hospital.
- Responsibilities could include providing accurate information to care providers, facilitating the delivery of care and respecting the rights of staff.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> Written and approved patient and family responsibilities statement.
Interviews	<ul style="list-style-type: none"> Who approves the patient responsibilities statement? Does the patient and family responsibilities comply with national law, if any?
Observation	<ul style="list-style-type: none"> The hospital has a patient responsibilities statement and is visible to patients.

Scoring:

- If there is a patient responsibilities statement in the hospital and it is visible to patients, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If there is no patient responsibilities statement in the hospital, score is not met.

B.2	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital builds health awareness for its patients and carers to empower them to share in making the right decisions regarding their care	Critical criterion	B.2.1.1 Informed consent is obtained before a procedure requiring informed consent by trained staff in a manner and language the patient or authorized person can understand.	Policies and procedures for informed consent that includes guidance on: <ul style="list-style-type: none"> ○ list of invasive procedures where informed consent is necessary ○ the information given to the patient ensuring that all risks, benefits and potential side-effects are explained and in advance of the procedure and any sedation.
	Core criteria	B.2.2.1 The hospital provides education that supports patient and family participation in care decisions and for general patient safety issues.	<ul style="list-style-type: none"> ● Educational material used, including, e.g. flyers, literature, lecture notes. ● Minutes of disease-specific support group meetings and signatures of attendance. ● Policies and procedures for health promotion.
		B.2.2.2 All patients obtain from their treating physicians complete updated information on their diagnosis and treatment.	Process for patients discharge summaries to include: <ul style="list-style-type: none"> ○ who is responsible ○ template of information to be made available.
		B.2.2.3 The hospital trains patients' and their carers in post-discharge care.	Process for training patients' carers in post-discharge care: care of patient, diet, safe and effective use of medical equipment, and rehabilitation.
		B.2.2.4 On admission, a full medical history, treatment plan and needs requirements are assessed and recorded in the patients' medical record.	<ul style="list-style-type: none"> ● Medical records detailing medical history and treatment plans. ● Integrated care pathways.
		B.2.2.5 On discharge, a detailed discharge/referral summary is shared with the patient and patient's primary physician.	Process for discharge summaries to include: <ul style="list-style-type: none"> ○ who is responsible ○ template of information to be shared.
		B.2.2.6 Education methods take into account the patient's and family's cultures, values and preferences.	Policy on health literacy.
		B.2.2.7 Patients are made aware and encouraged to use their voice in relation to the three WHO Global Patient Safety Challenges (Safe Surgery Saves Lives, Clean Care is Safer Care, and Medication Without Harm).	Patients have a voice and are encouraged to raise their voice in relation to safe care. The three WHO Global Patient Safety Challenges are: <ol style="list-style-type: none"> 1. Clean Care is Safer Care (hand hygiene). 2. Safe Surgery Saves Lives (what you need to know before and after surgery). 3. Medication Without Harm (5 Moments for Medication Safety).
	Developmental criteria	B.2.3.1 The hospital encourages patients to participate in planning and making decisions regarding their health care, including discharge or referral.	<ul style="list-style-type: none"> ● Process to encourage patients to participate in planning and making decisions regarding their health care. ● Planning for discharge or referral to include patients. ● If death is the outcome, planning could include the preparation of patients and their families for death, the management of pain and symptoms, linkage with support groups, counselling, and addressing spiritual and cultural needs.
	B.2.3.2 The hospital provides patient safety advice through multiple mediums, including printed material, social media and on a publicly accessible website.	<ul style="list-style-type: none"> ● Hospital health care website. ● Patient access to hospital health care website. 	

B.2.1.1 Informed consent is obtained, before a procedure requiring informed consent, by trained staff in a manner and language the patient or authorized person can understand.

Measurable elements:

- Policies and procedures for informed consent.
- Training records of staff trained in informed consent policies and procedures.
- Process to measure compliance with informed consent policies and procedures.
- List of procedures for which informed consent is required includes, but is not limited to: invasive procedures; surgical procedures; anaesthesia; blood transfusion; high-risk procedures; high-risk treatments; and organ donation and transplantation.
- Informed consent forms that are available in relevant departments.
- Informed consent forms that are completed, signed, dated and timed, and available in patients' medical records.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for informed consent. • Training records of staff trained in policies and procedures for informed consent. • Documents to measure compliance with informed consent policies and procedures. • List of procedures for which informed consent is required, including, but not limited to: invasive procedures; surgical procedures; anaesthesia; blood transfusion; high-risk procedures; high-risk treatments; and organ donation and transplantation. • Systematic random sample medical record review: informed consent form is completed, signed, dated and timed and available in patient's medical records.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of implementation of informed consent policy? • Patients or authorized person: What were the steps taken before you signed the informed consent form?
Observation	<ul style="list-style-type: none"> • Informed consent forms are available in relevant departments.

Scoring:

- If before any invasive procedures, a consent form is signed by patients, and patients are informed of all risks of a procedure in advance, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If there is no evidence, before any invasive procedures, of a signed consent by patients, score is not met.

B.2.2.1 The hospital provides education that supports patient and family participation in care decisions and for general patient safety issues.

Measurable elements:

- Policies and procedures for health education.
- Educational material used, including flyers, literature or lecture notes.
- Minutes of the last three disease-specific support group meetings and signatures of attendance.
- Training records of staff trained in policies and procedures for health education.
- Process to measure compliance with policies and procedures for health education.
- Completed health education needs assessment form in medical records.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Educational material used, including flyers, literature or lecture notes. • Policies and procedures for health education on specific health issues and patient safety. • Training records of staff trained in health education policies and procedures. • Documents showing compliance with health education policies and procedures. • Minutes of the last three disease-specific support group meetings and signatures of attendance. • Medical records review: completed health education form.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital builds health awareness for all of its patients and their families for their specific health problems and for general patient safety issues? • Patients: Did you receive any health promotion about your specific health problem and for general patient safety issues?
<p>Observation</p>	<ul style="list-style-type: none"> • Educational material used, including flyers in waiting areas, admission rooms, etc.

Scoring:

- If the hospital builds health awareness for all of its patients and their families for their specific health problems and for general patient safety issues, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not build health awareness for its patients and their families for their specific health problems and for general patient safety issues, score is not met.

B.2.2.2 All patients obtain from their treating physicians complete updated information on their diagnosis and treatment.**Measurable elements:**

- Policies and procedures for providing complete updated information on patients' diagnosis and treatment.
- Training records of staff trained in policies and procedures for complete updated information on patients' diagnosis and treatment.
- Process to measure compliance with policies and procedures for complete updated information on patients' diagnosis and treatment.
- Completed forms in medical records signed, dated and timed by treating physicians and patients or authorized persons.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for complete updated information on patients' diagnosis and treatment. • Training records of staff trained in policies and procedures for complete updated information on patients' diagnosis and treatment. • Documents showing compliance with policies and procedures for complete updated information on patients' diagnosis and treatment. • Medical records review: completed clinical care plan for both diagnosis and treatment forms.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that all patients obtain from their treating physicians complete updated information on their diagnosis and treatment? • Patients: Were you always updated about your diagnosis and treatment?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If all patients obtain complete updated information from their treating physicians on their diagnosis and treatment, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If patients generally do not obtain from their treating physicians complete updated information on their diagnosis and treatment, score is not met.

B.2.2.3 The hospital trains patients' and their carers in post-discharge care.**Measurable elements:**

- Process for training patients' carers in post-discharge care: care of patient; diet; safe and effective use of medical equipment; and rehabilitation.

- Policies and procedures for training patients' carers in post-discharge care.
- Training records of staff trained in policies and procedures for training patients' carers in post-discharge care.
- Process to measure compliance with policies and procedures for training patients' carers in post-discharge care.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for training patients' carers in post-discharge care. • Training records of staff trained in policies and procedures for training patients' carers in post-discharge care. • Document that includes compliance with policies and procedures for training patients' carers in post-discharge care. • Systematic random sample of medical record review: completed post-discharge care training form.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of training patients' carers in post-discharge care? • Patients: Were you and/or your carers trained in post-discharge care?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital trains patients' carers in post-discharge care, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not provide training for patients' carers in post-discharge care, score is not met.

B.2.2.4 On admission, a full medical history, treatment plan and needs requirements are assessed and recorded in the patients' medical record.

Measurable elements:

- Patients' medical records detailing their respective medical history on admission.
- Medical records that illustrate treatment plans and management needed for each respective patient.
- Documents that clarify needed medical equipment and medications for each patient's management plan.
- Documents that show responsible departments for managing the case and ways of communications between those departments to provide integrated health care services.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Patients' medical records detailing their respective medical history on admission. • Follow-up charts for each patient, which starts by the medical condition of each patient on admission. • Medical records that illustrate treatment plans and management needed for each respective patient. • Documents that clarify needed medical equipment and medications for each patient's management plan. • Documents that show responsible departments for managing the case and ways of communications between those departments to provide integrated health care services.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: What is the regular practice you as a staff member do with a new admission? • Is there a proper documentation with a follow-up chart for each admitted patient that starts with his/her clinical condition on admission?
<p>Observation</p>	<ul style="list-style-type: none"> • A file with all relevant documents for each patient is available and approachable anytime for all relevant staff.

Scoring:

- If the hospital has a clear system for making medical records for each patient on admission, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a system for medical records, score is not met.

B.2.2.5 On discharge, a detailed discharge/referral summary is shared with the patient and patients' primary physician.**Measurable elements:**

- Discharge/referral summary is in place to be prepared and given to all patients upon discharge/referral from the hospital.
- Discharge/referral summary is shared with the patient's primary health care physician.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Discharge summary to be given for the patient on discharge. • Referral/discharge summary to be shared with the discharged patient's primary health care physician for follow-up and updating records.
Interviews	<ul style="list-style-type: none"> • Is there a clear structure for the discharge summary for patients? • Is all clinical and management information shared with the patients' primary health care physicians after discharge?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has a discharge/referral summary for patients on discharge, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a system for discharging patients and sharing their clinical data with patients and primary health care physicians, score is not met.

B.2.2.6 Health education methods take into account the patient's and family's cultures, values and preferences.

Measurable elements:

- Documents that show the hospital's policy on health literacy.
- Health education tools and activities that are applied in the hospital.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • The hospital's policy on health literacy. • Reports of health education activities that have been conducted in the hospital. • Tools that are used to deliver health education messages.
Interviews	<ul style="list-style-type: none"> • Is there a clear policy for delivering health education messages in languages and methods that fit the patient's culture and environment? • Does the target audience extend beyond the hospital's patients to include families and surrounding community?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital considers education methods that are compatible with patients' and family's culture, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not take into account the surrounding culture in their health education policy and methods, score is not met.

B.2.2.7 Patients are made aware and encouraged to use their voice in relation to the three WHO Global Patient Safety Challenges (Safe Surgery Saves Lives, Clean Care is Safer Care, and Medication Without Harm).

Measurable elements:

- Awareness documents and activities to deliver the guidelines and instructions of hand hygiene for the staff as well as patients and families.
- Documents that educate patients about instructions before and after surgeries and encourage them to speak up and ask for services.
- Health education materials and instructions to ensure medication safety.
- Reporting/complaining system and policy to enable patients to speak up for their needs to ensure safe health care.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies that show reporting/complaining system that enable patients to speak up for their right to get safer care. • Reports that show activities to deliver the guidelines and instructions of hand hygiene for the staff as well as patients and families. • Documents that educate patients about instructions before and after surgeries and encourage them to speak up and ask for services. • Health education materials and instructions to ensure medication safety.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Are the staff aware of the guidelines for hand hygiene and applying them? • Relevant staff from the surgical team: Are they aware of patient safety requirements before, during and after the surgery? • Relevant staff: Are there recommendations and processes in place to ensure medication safety?
Observation	<ul style="list-style-type: none"> • Signs that show guidelines and instructions for proper hand hygiene. • Information signs that show the "5 moments" for medication safety, or other relevant instruction (see the WHO Global Patient Safety Challenges: Medication Without Harm [5 Moments for Medication Safety]).

Scoring:

- If the hospital considers methods to make patients aware and encourage them to speak up for the WHO Global Patient Safety Challenges, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not take into account involving patients into addressing the WHO global health challenge, score is not met.

B.2.3.1 The hospital encourages patients to participate in planning and making decisions regarding their health care, including discharge or referral.**Measurable elements:**

- Process to encourage patients to participate in planning and making decisions regarding their health care.
- Policies and procedures to encourage patients to participate in planning and making decisions regarding their health care.
- Process to encourage patients to participate in planning discharge or referral.
- Training records of staff trained in policies and procedures to encourage patients to participate in planning and making decisions regarding their health care.
- Process to measure compliance with policies and procedures to encourage patients to participate in planning and making decisions regarding their health care.
- Forms signed, dated and timed by patients regarding their participation in planning and making decisions regarding their health care.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for patients to participate in planning and making decisions regarding their health care. • Training records of staff trained in policies and procedures to encourage patients to participate in planning and making decisions regarding their health care. • Process to measure compliance with relevant policies and procedures to encourage patients to participate in planning and making decisions regarding their health care. • Systematic random sample of medical record review: relevant forms signed, dated and timed by patients regarding their participation in planning and making decisions regarding their health care. • Process to encourage patients to participate in planning discharge or referral. • Patient's medical records to show involvement of the patient in the planning discharge or referral. • If death was the outcome, evidence that planning includes the preparation of patients and their families for death, the management of pain and symptoms, linkage with support groups, counselling and addressing spiritual and cultural needs.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that patients participate in planning and making decisions regarding their health care? • Patients: Did you participate in planning and making decisions regarding your health care?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If patients participate in planning and making decisions regarding their health care, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If patients do not participate in planning and making decisions regarding their health care, score is not met.

B.2.3.2 The hospital provides patient safety advice through multiple mediums, including printed material, social media and on a publicly accessible website.**Measurable elements:**

- The hospital has material for advice on patient safety.
- Patient safety advice is provided through multiple mediums, including printed material, social media and websites.
- Patient has access to the hospital health care website.
- The hospital has publicly accessible social media channels.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Health education material. • Patient safety education material. • Frequent questions and answers.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of a hospital website, and how often it is updated? • Patients: Were you aware that you can access information on the hospital website?
Observation	<ul style="list-style-type: none"> • Hospital website, social media channel.

Scoring:

- If the hospital has a website having educational material and patients have access to it, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not a website or educational material is not available and/or patients do not have access to it, score is not met.

B.3	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital ensures best practice of patient identification and verification at all stages of care	Critical criterion	B.3.1.1 The identification process used throughout the hospital requires at least two ways in which to identify a patient.	<ul style="list-style-type: none"> • Policies and procedures for patient identification and verification, including two identifiers known to the patient. • The patient identifiers include the full name of patient (to the third generation of the family), date of birth, photograph and hospital number, and are used consistently throughout the hospital.
	Core criterion	B.3.2.1 A system is in place to identify and document allergies.	<ul style="list-style-type: none"> • Policies and procedures for patient identification and verification, including two identifiers known to the patient. • The patient identifiers include the full name of patient (to the third generation of the family), date of birth, photograph and hospital number, and are used consistently throughout the hospital.
		B.3.2.2 The patient's right to privacy and confidentiality of care and information are respected.	Policy on: <ul style="list-style-type: none"> ○ storage of medical records ○ restricted access to patient data.
	Developmental criterion	B.3.3.1 The hospital uses barcoding for patient identification.	Policy on using barcoding to identify patients while administering: <ul style="list-style-type: none"> ○ storage of medical records ○ restricted access to patient data ○ matching of laboratory samples ○ matching of medical imaging.

B.3.1.1 The identification process used throughout the hospital requires at least two ways in which to identify a patient.

Measurable elements:

- Policies and procedures for patient identification and verification, including two identifiers known to the patient. Patient identifiers include full name of the patient (to three generations of the family where possible) and date of birth, the name of the treating physician, room or bed number and are consistent throughout the hospital.
- Policies for patient identification using two identifiers before administration of medication, carrying out any procedure and verification of identity before any high-risk procedures.
- List of high-risk procedures, including blood transfusion and chemotherapy administration.
- Patient identification and verification policies and procedures that contain special emphasis on high-risk groups (e.g. newborn infants, patients in a coma, senile patients).
- Using barcoding system to identify patients' medications and blood products.
- Training records of staff trained in policies and procedures for patient identification and verification.
- Process to measure compliance with policies and procedures for patient identification and verification.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Policies and procedures for patient identification and verification. • Policies and procedures for patient identification and verification that contain special emphasis on high-risk groups (e.g. newborn infants, patients in a coma, senile patients). • List of high-risk procedures. • Barcoding system to match patients' medication and blood products. • Training records of staff trained in policies and procedures for patient identification and verification. • Reports that measure compliance with policies and procedures for patient identification and verification. • Sample of randomly selected medical records to review patient identifiers.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that patients are identified before providing treatments (e.g. administering medication, blood or blood products, serving a restricted diet or radiotherapy) before performing procedures (e.g. insertion of an intravenous line or haemodialysis) and before any diagnostic procedures (e.g. taking blood and other specimens for clinical testing, cardiac catheterization or diagnostic radiology procedures). Is identification of patients in a coma with no identification also included? • Patients: How do staff identify you?
<p>Observation</p>	<ul style="list-style-type: none"> • Patient identification wristbands or other ways. • Patient identifiers in medical records and any other medical request.

Scoring:

- If all patients are identified and verified with at least two identifiers, including full name and date of birth whenever the patient undergoes any procedures, is transferred or is administered any medication or blood or blood component before care is administered, with special emphasis on high-risk groups, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If there is no system in place to identify patients appropriately, score is not met.

B.3.2.1 A system is in place to identify and document allergies.

Measurable elements:

- System in place to identify allergies, e.g. a colour-coding system.
- Policies and procedures for identification of allergies.
- Training records of staff trained in policies and procedures for identification of allergies.
- Process to measure compliance with policies and procedures for identification of allergies.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • System in place to identify allergies, e.g. a colour-coding system. • Policies and procedures for identification of allergies. • Training records of staff trained in policies and procedures for identification of allergies. • Documents or reports to measure compliance with policies and procedures for identification of allergies.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of a system in place to identify allergies, e.g. a colour-coding system?
Observation	<ul style="list-style-type: none"> • A system in place to identify allergies, e.g. a colour-coding system.

Scoring:

- If there is a system in place to identify allergies, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If there is no system in place to identify allergies, score is not met.

B.3.2.2 The patient's right to privacy and confidentiality of care and information are respected.**Measurable elements:**

- The hospital's policy to ensure privacy and confidentiality of the patients' records.
- Security considerations for patients' records storage.
- Methods to ensure restricted access to this information for relevant staff only.
- Staff are aware of the patient's right to privacy and confidentiality of care and information and respect it.
- Investigating methods in case of breaching privacy and confidentiality considerations of any patient.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Documents showing the hospital's policy to ensure privacy and confidentiality of patients' records. • Barcoding system to match patients' medication and blood products. • Instructions given to all staff to secure patients' personal and medical information. • Staff are aware of patient's right to privacy and confidentiality of care and information and respect it. • Investigating processes in case of breaching one of the confidentiality considerations for any patient.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there a clear policy that ensures privacy and confidentiality of patients' records? • Relevant staff: Are you aware of patient's rights and how to report any suspected breaching incident for patient's confidentiality?
Observation	<ul style="list-style-type: none"> • Any measures implemented to protect confidentiality and privacy.

Scoring:

- If the hospital has a clear statement and compliance with measurable elements to ensure privacy and confidentiality of patients, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not follow measure to ensure privacy and confidentiality for patients, score is not met.

B.3.3.1 The hospital uses barcoding for patient identification.

Measurable element:

- System for barcoding with check digits for patient identification.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Documents explaining barcoding with check digits to ensure proper patient identification.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of barcoding with check digits to ensure proper patient identification?
Observation	<ul style="list-style-type: none"> • Patient identification bands with barcodes with check digits. • Patient identification barcodes with check digits on medical records forms.

Scoring:

- If the hospital uses barcoding with check digits for patient identification, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not use barcoding with check digits for patient identification, score is not met.

B.4	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital involves the community in different patient safety activities	Critical criteria	B.4.2.1 The hospital conducts patient safety campaigns that share solutions and raise awareness of patient safety in the community.	<ul style="list-style-type: none"> Process to plan patient safety campaigns. Communities of practice. Minutes of meetings and action plan for patient safety campaign. Minutes of meetings with civic groups, nongovernmental organizations and community leaders.
		B.4.2.2 The hospital uses media and/or marketing to promote patient safety.	<ul style="list-style-type: none"> Media material to promote patient safety (e.g. press releases announcing patient safety activities). Marketing material to promote patient safety (e.g. press releases announcing patient safety activities).
	Developmental criteria	B.4.3.1 The hospital involves the community in designing and implementing patient safety programmes and improvement projects.	<ul style="list-style-type: none"> Strategy for community involvement (e.g. nongovernmental organizations, patient advocates and communities of practice). Policies and procedures for community involvement.
		B.4.3.2 Patients have access to their medical records with the opportunity to seek clarification from the relevant medical practitioner.	<ul style="list-style-type: none"> Policy on how patients can request access to medical records.

B.4.2.1 The hospital conducts patient safety campaigns that share solutions and raise awareness of patient safety in the community.

Measurable elements:

- Process to plan patient safety campaigns.
- Minutes of meetings and action plan for the patient safety campaign.

Evaluation process

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> Reports showing how the patient safety campaign was planned. Minutes of meetings and action plan for the patient safety campaign.
Interviews	<ul style="list-style-type: none"> Is there evidence of a patient safety campaign?
Observation	<ul style="list-style-type: none"> Not applicable.

Scoring:

- If the hospital conducts patient safety campaigns that share solutions and raise awareness of patient safety in the community, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conduct patient safety campaigns that share solutions and raise awareness of patient safety in the community, score is not met.

B.4.2.2 The hospital uses media and/or marketing to promote patient safety.**Measurable elements:**

- Media material to promote patient safety (e.g. press releases announcing patient safety activities).
- Marketing material to promote patient safety (e.g. press releases announcing patient safety activities).

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Media material to promote patient safety (e.g. press releases announcing patient safety activities). • Marketing material to promote patient safety (e.g. press releases announcing patient safety activities).
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of use of media and/or marketing to promote patient safety (e.g. press releases announcing patient safety activities)?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital uses media and marketing to promote patient safety, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not use media and marketing to promote patient safety, score is not met.

B.4.3.1 The hospital involves the community in designing and implementing patient safety programmes and improvement projects.**Measurable elements:**

- Strategy for community involvement (e.g. nongovernmental organizations and patient advocates).
- Written and verbal information provided to community leaders about their role in patient safety improvement.
- Policies and procedures for community involvement.
- Training records of staff trained in community involvement policies and procedures.
- Reports that include measuring compliance with relevant community involvement policies and procedures.
- Patient safety improvement task force minutes or reports of meetings.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Strategy for community involvement (e.g. nongovernmental organizations and patient advocates). • Policies and procedures for community involvement. • Training records of staff trained in community involvement policies and procedures. • Reports that include measuring compliance with community involvement policies and procedures. • Patient safety improvement task force minutes or reports of meetings.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of community involvement (e.g. nongovernmental organizations, religious institutions and patient advocates) in designing and implementation of the patient safety programme?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital involves the community in designing and implementation of its patient safety programme, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not involve the community in designing and implementation of patient safety programme, score is not met.

B.4.3.2 Patients have access to their medical records with the opportunity to seek clarification from the relevant medical practitioner.**Measurable elements:**

- Policies and procedures for patients to have access to their medical records.
- Training records of staff trained in policies and procedures for patients to have access to their medical records.
- Process to measure compliance with policies and procedures for patients to have access to their medical records.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Policies and procedures for patients to have access to their medical records. • Training records of staff trained in policies and procedures for patients to have access to their medical records. • Reports that include measuring compliance with policies and procedures for patients to have access to their medical records.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that patients have access to their medical records with the opportunity to review and amend?
<p>Observation</p>	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If patients have access to their medical records with the opportunity to review and amend, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If patients do not have access to their medical records with the opportunity to review and amend, score is not met.

B.5	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital communicates patient safety incidents to patients and their carers	Core criteria	B.5.2.1 The hospital has a policy on disclosure of incidents to staff, patients and their carers.	<ul style="list-style-type: none"> • Policies and procedures for disclosure to patients and their carers and staff. • Evidence of previous cases of incidents regarding patients and the follow-up.
		B.5.2.2 The hospital has a patient advocacy service to explain information received from the clinical team or incidents to patients and their carers.	<ul style="list-style-type: none"> • Job description for the patient advocate or equivalent. • List of services that the patient advocate provides. • Evidence of training the patient advocate receives, i.e. communication skills to help patients and their carers understand health care issues.

B.5.2.1 The hospital has a policy on disclosure of incidents to staff, patients and their carers.

Measurable elements:

- Policy and procedure for disclosure to patients and their carers and staff.
- Training records of staff trained in disclosure policy and procedure.
- Process to measure compliance with disclosure policy and procedure.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policy and procedure for disclosure to patients and their carers and staff. • Training records of staff trained in disclosure policy and procedure. • Reports that measure compliance with disclosure policy and procedure.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of a structured disclosure system to patients, their carers and staff?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has a structured disclosure system, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a structured disclosure system, score is not met.

B.5.2.2 The hospital has a patient advocacy service to explain information received from the clinical team or incidents to patients and their carers.**Measurable elements:**

- Health care advocate/mediator terms of reference.
- Health care advocate/mediator notification letter.
- Health care advocate/mediator trained to explain incidents to patients and their carers.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Health care advocate/mediator terms of reference. • Health care advocate/mediator notification letter. • Health care advocate/mediator training records.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of a health care advocate/mediator to explain incidents to patients and their carers?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has a health care advocate/mediator to explain incidents, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a health care advocate/mediator to explain incidents, score is not met.

B.6	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital encourages feedback from patients and acts upon the patients' concerns and compliments	Core criteria	B.6.2.1 The hospital obtains patients' and their carers' feedback through both reactive and proactive processes.	<ul style="list-style-type: none"> • Process for reactive measurement: <ul style="list-style-type: none"> ○ complaints ○ incident reports. • Process for proactive measurement: <ul style="list-style-type: none"> ○ experience surveys ○ suggestion boxes ○ patient reported outcome measures (PROMs). • Action plans following patient feedback. • Communicating results to patients and staff.
		B.6.2.2 There is a process for feedback (compliment or complaint or improvement) that includes how to receive, investigate and resolve in a defined time and the process is made available to patients, their family and the public.	Random sample of feedback on how complaints were managed and changes that have taken place to prevent recurrence of the complaints.
	Developmental criteria	B.6.3.1 The hospital involves patients and their carers in governance structures, developing policies and in implementing quality improvement and patient safety projects.	Strategy for engagement of patients for patient safety, including: <ul style="list-style-type: none"> ○ patient identification and monitoring ○ hand hygiene ○ validate existence of any educational material used for patients relating to patient safety activities. ○ reports of meetings that include engagement of patients and their carers in setting policies and suggesting quality improvement and patient safety projects.
		B.6.3.2 The hospital provides information and educates patients on patient safety, health literacy and patient well-being.	Information and education on patient safety, health literacy and patient well-being.

B.6.2.1 The hospital obtains patients' and their carers' feedback through both reactive and proactive processes.

Measurable elements:

- Process to obtain patients' and their carers' feedback through different tools, e.g. satisfaction surveys, leadership walk-rounds, focus groups, complaint letters, safety hotline, staff feedback, suggestion box and community focus groups.
- Reactive complaints and incident reports.
- Proactive, experience surveys and suggestion boxes.
- PROMs.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> Satisfaction surveys, leadership walk-rounds, focus groups, complaint letters, safety hotline, staff feedback, suggestion box, minutes of community focus groups.
Interviews	<ul style="list-style-type: none"> Relevant staff: Is there evidence that hospital obtains patients' and their carers' feedback?
Observation	<ul style="list-style-type: none"> Suggestion box.

Scoring:

- If the hospital obtains patients' and their carers' feedback through different tools, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not obtain patients' and their carers' feedback, score is not met.

B.6.2.2 There is a process for feedback (compliment or complaint or improvement) that includes how to receive, investigate and resolve in a defined time and the process is made available to patients, their family and the public.

Measurable element:

- Random sample of feedback on how it was managed and changes that have taken place to prevent recurrence of negative feedback or complaints.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> Feedback reports on how patients' complaints were managed and changes that have taken place to prevent recurrence of the complaints.
Interviews	<ul style="list-style-type: none"> Relevant staff: Is there evidence of feedback reports on how patients' complaints were managed and changes that have taken place to prevent further recurrence of the complaints?
Observation	<ul style="list-style-type: none"> Not applicable.

Scoring:

- If the hospital responds to patients' complaints by sending them feedback on how the complaints were managed and the changes that have taken place to prevent recurrence of the complaints, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not respond to patients' complaints by sending them feedback on how complaints were managed and changes that have taken place to prevent recurrence of the complaints, score is not met.

B.6.3.1 The hospital involves patients and their carers in governance structures, developing policies and in implementing quality improvement and patient safety projects.

Measurable elements:

- Strategy for engagement and empowerment of patients for patient safety. Areas of patient involvement may include: patient identification, monitoring hand hygiene and single use of injections.
- Existence of any educational material and/or written/verbal information provided to patients that empowers them to play an active role and become partners for promoting patient safety.
- Policies and procedures for patient empowerment and engagement.
- Training records of staff trained in policies and procedures.
- Process to measure compliance with policies and procedures.
- Reports or minutes of meetings that include engagement of patients and their carers in setting policies and suggesting quality improvement and patient safety projects.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Strategy for engagement of patients or patient safety associations in patient safety. • Policies and procedures for patient engagement for patient safety. • Training records of staff trained in policies and procedures for patient engagement with patient safety reports that include measuring compliance with policies and procedures for patient engagement for patient safety reports or minutes of meetings that include engagement and partnership with patients and their carers in setting policies and suggesting quality improvement and patient safety projects.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of engagement of patients and their carers in setting policies and suggesting quality improvement and patient safety projects.
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If hospital involves patients and their carers in setting policies and suggesting quality improvement and patient safety projects, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If hospital does not involve patients and their carers in setting policies and suggesting quality improvement and patient safety projects, score is not met.

B.6.3.2 The hospital provides information and educates patients on patient safety, health literacy and patient well-being.

Measurable elements:

- Hospital provides information and educates patients on patient safety and health literacy, including how to maintain and improve their own well-being as well as providing information on patient safety.
- Maintaining and improving their own well-being could include requirements relating to smoking cessation programmes, stress management advice, diet and exercise guidance and substance abuse management.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Information on patient safety and health literacy, including how to maintain and improve their own well-being. • Material on smoking cessation programmes, stress management advice, diet and exercise guidance and substance abuse management. • Patient medical records.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of information on patient safety, health literacy and patient well-being? • Patients: Is the organization providing information on patient safety, health literacy and patient well-being?

Scoring

- If the hospital provides access to information on patient safety, health literacy and patient well-being, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not provide access to information on patient safety, health literacy and patient well-being, score is not met.

B.7	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has a patient safety friendly environment	Core criteria	B.7.2.1 The hospital provides patients with a private, confidential and gender-friendly environment.	Tour of the environment demonstrating evidence of: <ul style="list-style-type: none"> O private examination space O gender-separated waiting areas O secure medical information.
		B.7.2.2 The hospital provides space for social interaction, including entertainment for patients.	Tour of the environment demonstrating evidence of: <ul style="list-style-type: none"> O entertainment for patients, e.g. music, television, films, library O space for meeting relatives
		B.7.2.3 The hospital has a place for prayers and meets patients' spiritual and religious needs.	Tour of the environment demonstrating evidence of private space for prayer and spiritual needs.

B.7.2.1 The hospital provides patients with a private, confidential and gender-friendly environment.

Measurable elements:

- There is privacy for examination of patients and information is kept confidential.
- There are gender-separated waiting areas.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Training material for staff to implement policy on privacy, confidentiality and a gender-friendly environment.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that hospital staff are trained to be supportive on this policy?
Observation	<ul style="list-style-type: none"> • Gender-friendly spaces for patient examination and waiting.

Scoring:

- If the hospital provides privacy for examination, waiting and gender-friendly spaces and staff are trained to implement these practices, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not provide privacy for examination, waiting and gender-friendly spaces and staff are not trained to implement these practices, score is not met.

B.7.2.2 The hospital provides space for social interaction, including entertainment for patients.**Measurable element:**

- Entertainment for patients, e.g. music, television, films, library.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Reports on entertainment for patients.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of entertainment for patients?
Observation	<ul style="list-style-type: none"> • Entertainment for patients, e.g. music, television, films or library.

Scoring:

- If the hospital has entertainment for patients, score is fully met;
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have entertainment for patients, score is not met.

B.7.2.3 The hospital has a place for prayers and meets patients' spiritual and religious needs.**Measurable element:**

- Hospital has a place for prayers and meets patients' spiritual and religious needs.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Reports on patients' spiritual and religious needs. • Patient satisfaction reports.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that patients' spiritual and religious needs are being met?
Observation	<ul style="list-style-type: none"> • Place for prayers and meeting patients' spiritual and religious needs.

Scoring:

- If the hospital has a place for prayers and meets patients' spiritual and religious needs, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a place for prayers and does not meet patients' spiritual and religious needs, score is not met.

Domain C: Safe evidence-based clinical practice

Domain	Standard statement	Number of criteria		
		Critical	Core	Developmental
C. Safe evidence-based clinical practice standards	C.1 The hospital has effective clinical governance that ensures inclusion of patient safety.	6	8	0
	C.2 The hospital has a system to reduce risk of hospital-acquired infections (HAIs).	3	8	1
	C.3 The hospital ensures safety of blood and blood products.	2	2	0
	C.4 The hospital has a safe medication system.	3	6	1
	Total	14	24	2

C.1	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has effective clinical governance that ensures inclusion of patient safety	Critical criteria	C.1.1.1 The hospital leadership maintains effective channels of communication throughout the hospital, including for urgent critical results.	<ul style="list-style-type: none"> • Communication strategy. • Process for communicating urgent critical results. • Use of information technology.
		C.1.1.2 The hospital implements the use of a surgical safety checklist and conforms to guidelines, including WHO guidelines on safe surgery.	<ul style="list-style-type: none"> • Process to ensure correct patient, surgical site and surgical procedure. • Surgical safety checklist used in operating rooms for every surgical procedure.
		C.1.1.3 The hospital has systems in place to ensure hospital-wide recognition of and response to clinical deterioration.	Policies and procedures for recognition of and response to clinical deterioration.
		C.1.1.4 The hospital minimizes use of verbal and telephone orders and transmission of results, and “read back” is practised where verbal communication is essential.	Policies for use of verbal telephone orders, including: <ul style="list-style-type: none"> ○ restricting use ○ read back.
		C.1.1.5 The hospital has systems in place for safe and thorough handover of patients between clinical teams and between shifts.	Policies and procedures for handover of patients to include: <ul style="list-style-type: none"> ○ all disciplines ○ changes in shifts ○ SBAR.
		C.1.1.6 The hospital implements safe childbirth guidelines and pathways of care.	<ul style="list-style-type: none"> • Evidence-based safe childbirth guidelines/pathways of care. • Information to patients about safe childbirth.
	Core criteria	C.1.2.1 The hospital has a process to develop clinical guidelines and a local clinical guideline committee that meets regularly to select, and ensure implementation of guidelines, protocols and checklists relevant to safety.	<ul style="list-style-type: none"> • Establish a multidisciplinary guideline committee and develop terms of reference • Prioritize clinical guidelines, checklists and policies to be developed. • Clinical practice guidelines based on the top five diagnoses and top five high-risk diseases, including WHO guidelines where available.
	C.1.2.2 The hospital has systems in place to ensure safe communication of pending test results to patients and care providers after discharge.	<ul style="list-style-type: none"> • Policies and procedures to ensure safe communication of pending test results to patients and care providers after discharge. • Use of information technology and social media. 	
	C.1.2.3 The hospital ensures invasive diagnostic procedures are carried out safely, and according to standard guidelines.	Guidelines for the top five invasive diagnostic procedures.	
	C.1.2.4 The hospital implements guidelines, to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).	<ul style="list-style-type: none"> • Process to identify patients at risk of deep venous thrombosis and pulmonary embolism and provide appropriate thromboprophylaxis. • Information provided by staff to patients about the risks of deep venous thrombosis and how to prevent it. • Guidelines to reduce deep venous thrombosis and pulmonary embolism. 	

	C.1.2.5 The hospital screens patients to identify those vulnerable to harm and acts to reduce risk.	Process that includes the availability of policies and procedures for initial and ongoing assessment to identify and manage patients at risk of the following: <input type="checkbox"/> pressure ulcers <input type="checkbox"/> suicide <input type="checkbox"/> infection <input type="checkbox"/> nutrition needs.
	C.1.2.6 The hospital maintains a list of approved abbreviations symbols and dose designations for use in hospitals	List of approved abbreviations.
	C.1.2.7 There is a process to integrate and coordinate the care provided to each patient within and between departments and with relevant external services.	Process to ensure patient-centric care.
	C.1.2.8 The hospital screens patients to identify those vulnerable to falls and acts to reduce risk.	Policies and procedures for: <input type="checkbox"/> identifying patients at risk by using an evidence-based assessment tool (Morse; Humpty Dumpty Falls Scale) <input type="checkbox"/> initial and ongoing assessment of patients at risk of falling <input type="checkbox"/> reducing risk of falls <input type="checkbox"/> management if high risk.

C.1.1.1 The hospital leadership maintains effective channels of communication throughout the hospital, including for urgent critical results.

Measurable elements:

- List of urgent critical results developed by a multispecialty committee.
- Policies and procedures for channels of communication for urgent critical results.
- Training records of staff trained in policies and procedures for channels of communication for urgent critical results.
- Process to measure compliance with policies and procedures for channels of communication for urgent critical results.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • List of urgent critical diagnostic results developed by a multispecialty committee. • Channels of communication for urgent critical results policy and procedure. • Training records of staff trained in policies and procedures for channels of communication for urgent critical results. • Systematic random sample reports that include measuring compliance with policies and procedures for channels of communication for urgent critical results.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital maintains clear channels of communication for urgent critical results?
Observation	<ul style="list-style-type: none"> • List of urgent critical results developed by multispecialty committee.

Scoring:

- If the hospital maintains clear channels of communication for urgent critical results, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not maintain clear channels of communication for urgent critical results, score is not met.

C.1.1.2 The hospital implements the use of a surgical safety checklist and conforms to guidelines, including WHO guidelines on safe surgery.**Measurable elements:**

- Process to ensure correct patient, surgical site and surgical procedure.
- Surgical safety checklist used in operating rooms for every surgical procedure.
- Training records of staff trained in surgical safety guidelines.
- Process to measure compliance with relevant surgical safety guidelines.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Surgical safety checklist used in operating rooms for every surgical procedure. • Training records of staff trained in surgical safety guidelines. • Reports that include measuring compliance with surgical safety guidelines.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of implementation of a surgical safety checklist and compliance with guidelines on safe surgery, including WHO guidelines?
Observation	<ul style="list-style-type: none"> • Evidence of use of surgical safety checklist in the operating room.

Scoring:

- If the hospital implements a surgical safety checklist and guidelines, including WHO guidelines, on safe surgery, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not implement a surgical safety checklist and guidelines for safe surgery, score is not met.

C.1.1.3 The hospital has systems in place to ensure hospital-wide recognition of and response to clinical deterioration.**Measurable elements:**

- Process to develop, implement and maintain a hospital-wide system for recognition of and response to clinical deterioration.
- Process to measure and document observations via general observation charts, including respiratory rate, oxygen saturation, blood pressure, heart rate, temperature, consciousness level, etc.

- Process to form rapid response teams and rehearse on a regular basis.
- Regular auditing and monitoring of processes by the medical emergency committee.
- Staff training on recognition and communication of clinical deterioration.
- Policies and procedures for recognition of and response to clinical deterioration.
- Training records of staff trained in policies and procedures for recognition of and response to clinical deterioration.
- Process to measure compliance with policies and procedures for recognition of and response to clinical deterioration.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for recognition of and response to clinical deterioration. • Training records of staff trained in policies and procedures for recognition of and response to clinical deterioration. • Reports that include measuring compliance with policies and procedures for recognition of and response to clinical deterioration.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of systems in place to ensure hospital-wide recognition of and response to clinical deterioration?
Observation	<ul style="list-style-type: none"> • Measurement and documentation of observations via general observation charts: respiratory rate, oxygen saturation, blood pressure, heart rate, temperature, consciousness level, etc.

Scoring:

- If the hospital has a system in place to ensure hospital-wide recognition of and response to clinical deterioration, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a system in place to ensure hospital-wide recognition of and response to clinical deterioration, score is not met.

C.1.1.4 The hospital minimizes use of verbal and telephone orders and transmission of results, and “read back” is practised where verbal communication is essential.

Measurable elements:

- Policies and procedures for effective communication, including “read back” whereby the verbal or telephone order is written down completely by the receiver, who then reads back the order, which is confirmed by the person who gave the order.
- Training records of staff trained in policies and procedures for effective communication.
- Process to measure compliance with policies and procedures for effective communication.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for effective communication. • Training records of staff trained in policies and procedures for effective communication. • Reports that include measuring compliance with policies and procedures for effective communication.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital minimizes use of verbal and telephone orders for transmission of results, and that “read back” is used where verbal communication is essential?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital minimizes use of verbal and telephone orders for transmission of results, and “read back” is used where verbal communication is essential, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not minimize use of verbal and telephone orders for transmission of results, and/or “read back” is not used where verbal communication is essential, score is not met.

C.1.1.5 The hospital has systems in place for safe and thorough handover of patients between clinical teams and between shifts.**Measurable elements:**

- Policies and procedures for handover of patients.
- Training records of staff trained in policies and procedures for handover of patients.
- Process to measure compliance with policies and procedures for handover of patients.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for handover of patients. • Training records of staff trained in policies and procedures for handover of patients. • Reports that include measuring compliance with policies and procedures for handover of patients.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has systems in place for safe and thorough handover of patients (e.g. SBAR) between clinical teams (including shift staff)?
Observation	<ul style="list-style-type: none"> • Handover of patients.

Scoring:

- If the hospital has systems in place for safe and thorough handover of patients between clinical teams, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.

- If the hospital does not have systems in place for safe and thorough handover of patients between clinical teams, score is not met.

C.1.1.6 The hospital implements safe childbirth guidelines and pathways of care.

Measurable elements:

- Staff provision of information to patients about safe childbirth.
- Safe childbirth checklist.
- Training records of staff trained in safe childbirth guidelines.
- Process to measure compliance with safe childbirth checklist.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • WHO safe childbirth checklist. • Safe childbirth guidelines. • Training records of staff trained in safe childbirth guidelines. • Reports that include measuring compliance with safe childbirth guidelines.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital implements safe childbirth guidelines, e.g. WHO safe childbirth checklist?
Observation	<ul style="list-style-type: none"> • Information given to patients about safe childbirth.

Scoring:

- If the hospital implements safe childbirth guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met
- If the hospital does not implement safe childbirth guidelines, score is not met.

C.1.2.1 The hospital has a process to develop clinical guidelines and a local clinical guideline committee that meets regularly to select, and ensure implementation of guidelines, protocols and checklists relevant to safety.

Measurable elements:

- Establish multidisciplinary clinical guidelines committee to develop local clinical guidelines.
- Clinical practice guidelines based on the top five diagnoses and top five high-risk diseases, including WHO guidelines where available.
- Training records of staff trained in relevant clinical practice guidelines.
- Process to measure compliance with relevant clinical practice guidelines.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • TORs for multidisciplinary clinical guidelines committee to develop local clinical guidelines. • Clinical practice guidelines based on the top five diagnoses and top five high-risk diseases, including WHO guidelines where available. • Training records of staff trained in relevant selected clinical practice guidelines. • Reports that include measuring compliance with relevant selected clinical practice guidelines.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conforms to clinical practice guidelines wherever appropriate, including WHO guidelines where available?
Observation	<ul style="list-style-type: none"> • Clinical pathways and reminders.

Scoring:

- If the hospital conforms to clinical practice guidelines wherever appropriate, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conform to clinical practice guidelines wherever appropriate, score is not met.

C.1.2.2 The hospital has systems in place to ensure safe communication of pending test results to patients and care providers after discharge.

Measurable elements:

- Policies and procedures to ensure safe communication of pending test results to patients and care providers after discharge.
- Training records of staff trained in relevant policies and procedures.
- Process to measure compliance with relevant policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures to ensure safe communication of pending test results to patients and care providers after discharge. • Training records of staff trained in policies and procedures for safe communication of pending test results to patients and care providers after discharge. • Reports that include measuring compliance with policies and procedures for safe communication of pending test results to patients and care providers after discharge.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of a system to ensure safe communication of pending test results to patients and care providers after discharge?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has systems to ensure safe communication of pending test results to patients and care providers after discharge, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have systems to ensure safe communication of pending test results to patients and care providers after discharge, score is not met.

C.1.2.3 The hospital ensures invasive diagnostic procedures are carried out safely, and according to standard guidelines.**Measurable elements:**

- Guidelines for top five invasive diagnostic procedures.
- Training records of staff trained in guidelines for invasive diagnostic procedures.
- Process to measure compliance with guidelines for invasive diagnostic procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Guidelines for top five invasive diagnostic procedures. • Training records of staff trained in relevant invasive diagnostic procedures guidelines. • Reports that include measuring compliance with guidelines for invasive diagnostic procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital ensures invasive diagnostic procedures are carried out safely, and according to standard guidelines?
Observation	<ul style="list-style-type: none"> • Invasive diagnostic procedures guidelines.

Scoring:

- If the hospital ensures invasive diagnostic procedures are carried out safely, and according to standard guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure invasive diagnostic procedures are carried out safely, and according to standard guidelines, score is not met.

C.1.2.4 The hospital implements guidelines, to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).

Measurable elements:

- Process to identify patients at risk of venous thromboembolism (deep venous thrombosis and pulmonary embolism) and provide appropriate thromboprophylaxis.
- Information provided by staff to patients about the risks of venous thromboembolism and how to prevent it.
- Guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).
- Training records of staff trained in guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).
- Process to measure compliance with guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism). • Training records of staff trained in guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism). • Process to measure compliance with guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has implemented guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism)?
Observation	<ul style="list-style-type: none"> • Mechanisms to identify patients at risk of venous thromboembolism (deep venous thrombosis and pulmonary embolism) and provide appropriate thromboprophylaxis. • Information for patients about the risks of venous thromboembolism and how to prevent it.

Scoring:

- If the hospital implements guidelines to reduce venous thromboembolism, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not implement guidelines to reduce venous thromboembolism, score is not met.

C.1.2.5 The hospital screens patients to identify those vulnerable to harm and acts to reduce risk.

Measurable elements:

- Process that includes the availability of policies and procedures for initial and ongoing assessment to identify and manage patients at risk for pressure ulcers, suicide, infection and nutrition needs.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for initial and ongoing assessment to identify and manage patients at risk for: pressure ulcer, suicide, infection and malnutrition. • Training records of staff trained in policies and procedures to identify and manage patients at risk for: pressure ulcer, suicide, infection and malnutrition. • Reports that include measuring compliance with policies and procedures for initial and ongoing assessment to identify and manage patients at risk for pressure ulcer, suicide, infection and nutrition needs. • Stratified random samples of medical records to review initial and ongoing assessment of, and compliance with, procedures to reduce the risk of pressure ulcer, suicide, infection and malnutrition.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital screens patients to identify those vulnerable to harm (e.g. for pressure ulcers, suicide, malnutrition and infection) and acts to reduce risk?
Observation	<ul style="list-style-type: none"> • Compliance with relevant policies and procedures for the following: pressure ulcers, suicide, infection and malnutrition.

Scoring:

- If the hospital screens patients to identify those vulnerable to harm and acts to reduce risk, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not screen patients to identify those vulnerable to harm and/or does not act to reduce risk, score is not met.

C.1.2.6 The hospital maintains a list of approved abbreviations symbols and dose designations for use in hospitals.

Measurable elements:

- List of approved abbreviations of medical terms.
- List of dangerous abbreviations, symbols and dose designations that are prohibited for use in hospitals.
- Lists applied in all medical-related documentation, whether hand written or computer

entries.

- Training records of staff trained in lists application.
- Process to identify non-approved abbreviations of medical terms and use of dangerous abbreviations, symbols and dose designations that are prohibited for use in hospitals.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • List of approved abbreviations of medical terms. • List of dangerous abbreviations, symbols and dose designations that are prohibited for use in hospitals. • Training records of staff trained in lists application. • Reports that include identification of non-approved abbreviations of medical terms and/or use of dangerous abbreviations, symbols and dose designations that are prohibited for use in hospitals.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital maintains a list of approved abbreviations of medical terms and a list of dangerous abbreviations, symbols and dose designations that are prohibited for use in the hospital?
Observation	<ul style="list-style-type: none"> • List of approved abbreviations of medical terms. • List of dangerous abbreviations, symbols and dose designations that are prohibited for use in hospitals.

Scoring:

- If the hospital maintains a list of approved abbreviations of medical terms, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not maintain a list of approved abbreviations of medical terms, score is not met.

C.1.2.7 There is a process to integrate and coordinate the care provided to each patient within and between departments and with relevant external services.

Measurable elements:

- Documents on guidelines and instructions for health care services regarding coordination of care, and to check if they include terms that ensure patient involvement, or not.
- Policies that ensure patient-centred health care and community involvement.
- Shared protocols and committees for shared planning of care for individual patient

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Documents that show guidelines and instruction followed for health care services and to check if they include terms that ensure patient involvement, or not. • Policies that ensure patient-centred health care and community involvement. • Shared protocols and committees for shared planning of care for individual patient.
<p>Interviews</p>	<ul style="list-style-type: none"> • Are there considerations and clear instructions to involve patients in health care services provided? • Are there guidelines applied in the hospital considering patient involvement, or not?
<p>Observation</p>	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital prioritizes patient involvement and integration in health care, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not count on involving patients in the provided health care services, score is not met.

C.1.2.8 The hospital screens patients to identify those vulnerable to falls and acts to reduce risk.

Measurable elements:

- Process of initial and ongoing assessment of patients at risk of falling, identifying them and establishing proactive risk management to reduce risk of falls.
- Policies and procedures for initial and ongoing assessment of patients at risk of falling.
- Policies and procedures to reduce risk of falls.
- Training records of staff trained in policies and procedures to reduce risk of falls.
- Process to measure compliance with policies and procedures to reduce risk of falls.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Policies and procedures to reduce risk of falls. • Training records of staff trained in policies and procedures to reduce risk of falls. • Reports that include measuring compliance with policies and procedures to reduce risk of falls. • Systematic random sample of medical records that review for initial and ongoing assessment of patients at risk of falling, and actions taken to reduce risk of falls.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital screens patients to identify those vulnerable to falls?
<p>Observation</p>	<ul style="list-style-type: none"> • Compliance with policies and procedures to reduce risk of falls.

Scoring:

- If the hospital screens patients to identify those vulnerable to falls, and acts to reduce the risk, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not screen patients to identify those vulnerable to falls and/or does not act to reduce the risk, score is not met.

C.2	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has a system to reduce the risk of hospital-acquired infections	Critical criteria	C.2.1.1 The hospital has a coordinated programme for all infection prevention and control (IPC) activities that involves all disciplines.	<ul style="list-style-type: none"> • Terms of reference for the IPC committee. • Minutes of IPC committee. • IPC guidelines, plan and manual. • Adoption of the WHO multimodal improvement strategy for effective prevention and control programmes.
		C.2.1.2 The hospital ensures proper cleaning, disinfection and sterilization of all equipment.	Policies for cleaning, disinfection and sterilization of equipment.
		C.2.1.3 There is a qualified, designated person responsible for all infection prevention and control (IPC) activities.	IPC organizational structure.
	Core criteria	C.2.2.1 The hospital conforms to evidence-based guidelines for infection prevention and control (IPC), including WHO multimodal improvement strategy for effective IPC programmes.	Recognized guidelines for IPC, including WHO guidelines.
		C.2.2.2 The hospital ensures continuous availability of essential, functioning infection prevention and control (IPC) equipment and supplies.	Policies and procedures for IPC equipment and supplies.
		C.2.2.3 The hospital has functioning isolation protocols, definitions and precautions.	Isolation protocols policies and procedures.
		C.2.2.4 The hospital implements policies and procedures for rational use of antibiotics to reduce resistance and has an active antimicrobial stewardship programme.	<ul style="list-style-type: none"> • Multidisciplinary approach composed of at least IPC, pharmacy, clinicians, hospital management and microbiology representation. • Policies and procedures for rational use of antibiotics to reduce resistance.
		C.2.2.5 The hospital implements recognized guidelines for hand hygiene, including WHO guidelines.	<ul style="list-style-type: none"> • Recognized guidelines for hand hygiene, including WHO guidelines.
		C.2.2.6 Staff are screened before employment and as best practice indicates, and afterwards for colonization and transmissible infections.	<ul style="list-style-type: none"> • Staff health records. • Staff screening policy and procedures.
		C.2.2.7 The hospital acts to protect staff and volunteers from health care-associated infections, including provision of hepatitis B vaccination.	<ul style="list-style-type: none"> • Policies and procedures for protection of staff and volunteers from health care-associated infections.
		C.2.2.8 The hospital conforms to bundle management wherever appropriate.	<ul style="list-style-type: none"> • Bundle management guidelines for: <ul style="list-style-type: none"> ○ Intensive care unit (ICU), including VAP and CLABSI ○ general, including UTI, severe sepsis.
Developmental criterion	C.2.3.1 The hospital has a surveillance system for hospital-acquired infections (HAIs).	<ul style="list-style-type: none"> • Policies and procedures for a surveillance system for HAIs, including: <ul style="list-style-type: none"> ○ surgical site infections ○ to track infection rates ○ analyse the information to determine clusters, trends and outbreaks ○ share information. 	

C.2.1.1 The hospital has a coordinated programme for all infection prevention and control (IPC) activities that involves all disciplines.

Measurable elements:

- Please use the WHO IPC core components and the IPC minimum standards requirements as a reference (<https://www.who.int/infection-prevention/tools/core-components/en/>).
- IPC organizational structure.
- Terms of reference and notification letter for the IPC committee.
- Minutes of IPC committee.
- IPC guidelines, plan and manual.
- IPC policies and procedures.
- Training records of staff trained in IPC policies and procedures.
- Process to measure compliance with IPC policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • IPC organizational structure. • Terms of reference and notification letter for the IPC committee. • Random sample of meeting minutes of IPC committee. • IPC policies and procedures. • Training records of staff trained in IPC policies and procedures. • Reports that include measuring compliance with infection prevention, and control policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has an IPC programme, including organization structure, guidelines, plan and manual?
Observation	<ul style="list-style-type: none"> • Compliance with IPC practices.

Scoring:

- If the hospital has an IPC programme, including organization structure, guidelines, plan and a manual, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have an IPC programme, score is not met.

C.2.1.2 The hospital ensures proper cleaning, disinfection and sterilization of all equipment.

Measurable elements:

- Policies and procedures for cleaning, disinfection and sterilization of equipment.
- Training records of staff trained in policies and procedures for cleaning, disinfection and sterilization of equipment.
- Process to measure compliance with cleaning, disinfection and sterilization of equipment policy and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for cleaning, disinfection and sterilization of equipment. • Training records of staff trained in policies and procedures for cleaning, disinfection and sterilization of equipment. • Reports that include measuring compliance with policies and procedures for cleaning, disinfection and sterilization of equipment.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital ensures proper cleaning, disinfection and sterilization of all equipment with a special emphasis on high-risk areas?
Observation	<ul style="list-style-type: none"> • Proper cleaning, disinfection and sterilization of equipment with a special emphasis on high-risk areas.

Scoring:

- If the hospital ensures proper cleaning, disinfection and sterilization of all equipment with a special emphasis on high-risk areas, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure proper cleaning, disinfection and sterilization of all equipment, score is not met.

C.2.1.3 There is a qualified, designated person responsible for all infection prevention and control (IPC) activities.

Measurable elements:

- IPC organizational structure.
- Terms of reference and job description of a responsible person for IPC.
- Regular monitoring reports provided by this responsible person to senior relevant staff for overcoming the identified gaps and challenges.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Documents that show the IPC organizational structure within the hospital. • Terms of reference and job description of a responsible person for IPC. • Regular monitoring reports provided by a responsible person to senior relevant staff for overcoming the identified gaps and challenges.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Does the IPC responsible staff member have the authority to supervise, monitor and develop activities to ensure IPC standards in the hospital?
Observation	<ul style="list-style-type: none"> • Not applicable

Scoring:

- If the hospital has a designated person responsible for IPC activities, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have IPC responsible person, score is not met.

C.2.2.1 The hospital conforms to evidence-based guidelines for infection prevention and control (IPC), including WHO multimodal improvement strategy for effective IPC programmes.

Measurable elements:

- Recognized guidelines for IPC, including WHO guidelines.
- Training records of staff trained in IPC guidelines.
- Process to measure compliance with IPC guidelines.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Recognized guidelines for IPC, including WHO guidelines. • Training records of staff trained in IPC guidelines. • Reports that include measuring compliance with IPC guidelines
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conforms to recognized guidelines for IPC, including WHO guidelines?
Observation	<ul style="list-style-type: none"> • Compliance with guidelines for IPC.

Scoring:

- If the hospital conforms to recognized guidelines for IPC, including WHO guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conform to recognized guidelines for IPC, including WHO guidelines, score is not met.

C.2.2.2 The hospital ensures continuous availability of essential, functioning infection prevention and control (IPC) equipment and supplies.

Measurable elements:

- Policies and procedures for IPC equipment and supplies.
- Training records of staff trained in policies and procedures for IPC equipment and supplies.
- Process to measure compliance with policies and procedures for IPC equipment and supplies.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for IPC equipment and supplies. • Training records of staff trained in policies and procedures for IPC equipment and supplies. • Reports that include measuring compliance with policies and procedures for IPC equipment and supplies.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence the hospital ensures continuous availability of essential, functioning IPC equipment and supplies?
Observation	<ul style="list-style-type: none"> • Availability of essential, functioning IPC equipment and supplies.

Scoring:

- If the hospital ensures continuous availability of essential, functioning IPC equipment and supplies, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure continuous availability of essential, functioning IPC equipment and supplies, score is not met.

C.2.2.3 The hospital has functioning isolation protocols, definitions and precautions.

Measurable elements:

- Isolation protocols policies and procedures.
- Training records of staff trained in isolation protocols policies and procedures.
- Process to measure compliance with isolation protocols policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Isolation protocols policies and procedures. • Training records of staff trained in isolation protocols policies and procedures. • Reports that include measuring compliance with isolation protocols policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has functioning isolation protocols, definitions and precautions?
Observation	<ul style="list-style-type: none"> • Compliance with isolation protocols, definitions and precautions.

Scoring:

- If the hospital has functioning isolation protocols, definitions and precautions, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have functioning isolation protocols, definitions and precautions, score is not met.

C.2.2.4 The hospital implements policies and procedures for rational use of antibiotics to reduce resistance and has an active antimicrobial stewardship programme.

Measurable elements:

- Multidisciplinary approach composed of at least (IPC), pharmacy, clinicians, hospital management and microbiology representation.
- Policies and procedures for rational use of antibiotics to reduce resistance.
- Training records of staff trained in policies and procedures for rational use of antibiotics and antimicrobial stewardship.
- Process to measure compliance with policies and procedures for rational use of antibiotics and antimicrobial stewardship.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for rational use of antibiotics to reduce resistance and antimicrobial stewardship. • Training records of staff trained in policies and procedures for rational use of antibiotics and antimicrobial stewardship. • Reports that include measuring compliance with policies and procedures for rational use of antibiotics and antimicrobial stewardship.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital implements policies and procedures for rational use of antibiotics to reduce resistance, and has an active antimicrobial stewardship programme?
Observation	<ul style="list-style-type: none"> • Compliance with policies and procedures for rational use of antibiotics and antimicrobial stewardship.

Scoring:

- If the hospital implements policies and procedures for rational use of antibiotics to reduce resistance, and has an active antimicrobial stewardship programme, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not implement policies and procedures for rational use of antibiotics to reduce resistance or have an active antimicrobial stewardship programme, score is not met.

C.2.2.5 The hospital implements recognized guidelines for hand hygiene, including WHO guidelines.**Measurable elements:**

- Recognized guidelines for hand hygiene, including WHO guidelines.
- Training records of staff trained in hand hygiene guidelines.
- Process to measure compliance with hand hygiene guidelines for hand washing and hand disinfection throughout the hospital.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Recognized current guidelines for hand hygiene, including WHO guidelines. • Training records of staff trained in relevant hand hygiene guidelines. • Reports that include measuring compliance with hand hygiene guidelines.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital implements recognized guidelines for hand hygiene, including WHO guidelines?
Observation	<ul style="list-style-type: none"> • Compliance with guidelines for hand hygiene, including WHO guidelines.

Scoring:

- If the hospital implements recognized guidelines for hand hygiene, including WHO guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not implement recognized guidelines for hand hygiene, including WHO guidelines, score is not met.

C.2.2.6 Staff are screened before employment and as best practice indicates, and afterwards for colonization and transmissible infections.

Measurable elements:

- Staff health records.
- Staff screening policy and procedures.
- Training records of staff trained in staff screening policy and procedures.
- Process to measure compliance with staff screening policy and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Staff health records. • Staff screening policy and procedures. • Training records of staff trained in staff screening policy and procedures. • Reports that include measuring compliance with staff screening policy and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that staff should be screened before employment and regularly afterwards for colonization and transmissible infections?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If 80–100% of staff are screened before employment and regularly afterwards for colonization and transmissible infections, score is fully met.
- If 60–79% of staff are screened before employment and regularly afterwards for colonization and transmissible infections, score is partially met.
- If <60% of staff are screened before employment and/or are irregularly screened afterwards for colonization and transmissible infections, score is not met.

C.2.2.7 The hospital acts to protect staff and volunteers from hospital-acquired infections, including provision of hepatitis B vaccination.

Measurable elements:

- Policies and procedures for protection of staff and volunteers from health care-associated infections.
- Training records of staff trained in policies and procedures for protection of staff and volunteers from health care-associated infections.
- Process to measure compliance with policies and procedures for protection of staff and volunteers from health care-associated infections.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for protection of staff and volunteers protection from health care-associated infections. • Training records of staff trained in policies and procedures for protection of staff and volunteers from health care-associated infections. • Reports that include measuring compliance with policies and procedures for protection of staff and volunteers from health care-associated infections.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital acts to protect staff and volunteers from health care-associated infections, including provision of hepatitis B vaccination?
Observation	<ul style="list-style-type: none"> • Actions that illustrate the implemented measures.

Scoring:

- If the hospital acts to protect staff, volunteers and visitors from health care-associated infections, including by hepatitis B vaccination, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not act to protect staff, volunteers and visitors from health care-associated infections, including by hepatitis B vaccination, score is not met.

C.2.2.8 The hospital conforms to bundle management wherever appropriate.**Measurable elements:**

- Bundle management guidelines.
- Training records of staff trained in bundle management.
- Process to measure compliance with bundle management implementation.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Bundle management guidelines. • Training records of staff trained in bundle management. • Reports that include measuring compliance with bundle management implementation.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of the hospital conforming to bundle management?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital conforms to bundle management wherever appropriate, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If hospital does not conform to bundle management wherever appropriate, score is not met.

C.2.3.1 The hospital has a surveillance system for hospital-acquired infections (HAIs).**Measurable elements:**

- Process to track infection rates; analyse the information to determine clusters, trends and outbreaks; and share information.
- Policies and procedures for surveillance system for health care-associated infections.
- Training records of staff trained in policies and procedures for surveillance system for health care-associated infections.
- Process to measure compliance with policies and procedures for surveillance system for health care-associated infections.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for surveillance system for health care-associated infections. • Training records of staff trained in policies and procedures for surveillance system for health care-associated infections. • Reports that include measuring compliance with policies and procedures for surveillance system for health care-associated infections.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that hospital has a surveillance system for health care-associated infections?
Observation	<ul style="list-style-type: none"> • Surveillance system for health care-associated infections.

Scoring:

- If the hospital has a surveillance system for health care-associated infections, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a surveillance system for health care-associated infections, score is not met.

C.3	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital ensures safety of blood and blood products	Critical criteria	C.3.1.1 The hospital implements guidelines, including WHO guidelines, on safe quality blood and blood products.	<ul style="list-style-type: none"> Guidelines, including WHO guidelines, on safe blood and blood products. Guidelines on safe administration of blood and blood products. Policies and procedures for safe pre-transfusion procedures, including for recruitment, selection and retention of voluntary blood donors, and blood screening (e.g. HIV and hepatitis B and C viruses). Guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids.
		C.3.1.2 The hospital ensures that patient blood samples for cross-matching are securely identified with two unique identifiers.	Policies and procedures for cross-matching blood samples.
	Core criteria	C.3.2.1 The hospital complies with guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids.	Guidelines for clinical practices that reduce blood loss and the need for blood transfusion.
		C.3.2.2 The hospital has policies and procedures for post-blood transfusion incident management.	Policy for post-blood transfusion incident management.

C.3.1.1 The hospital implements guidelines, including WHO guidelines, on safe quality blood and blood products.

Measurable elements:

- Guidelines, including WHO guidelines, on safe blood and blood products.
- Guidelines on safe administration of blood and blood products.
- Training records of staff trained in guidelines on safe blood and blood products.
- Process to measure compliance with guidelines on safe blood and blood products.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> Guidelines, including WHO guidelines, on safe blood and blood products. Training records of staff trained in safe blood and blood products guidelines. Reports that include measuring compliance with safe blood and blood products guidelines.
Interviews	<ul style="list-style-type: none"> Relevant staff: Is there evidence that the hospital implements guidelines, including WHO guidelines, on safe blood and blood products?
Observation	<ul style="list-style-type: none"> Compliance with guidelines, including WHO guidelines, on safe blood and blood products.

Scoring:

- If the hospital implements guidelines, including WHO guidelines, on safe blood and blood products, score is fully met.
- If the hospital has guidelines on safe blood and blood products, but does not regularly implement them, score is partially met.
- If the hospital does not have guidelines on safe blood and blood products, score is not met.

C.3.1.2 The hospital ensures that patient blood samples for cross-matching are securely identified with two unique identifiers.

Measurable elements:

- Policies and procedures for cross-matching blood samples.
- Training records of staff trained in policies and procedures for cross-matching blood samples.
- Process to measure compliance with policies and procedures for cross-matching blood samples.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> Policies and procedures for cross-matching blood samples. Training records of staff trained in policies and procedures for cross-matching blood samples. Reports that include measuring compliance with policies and procedures for cross-matching blood samples.
Interviews	<ul style="list-style-type: none"> Relevant staff: Is there evidence that the hospital ensures that patient blood samples for cross-matching are securely identified with two unique identifiers?
Observation	<ul style="list-style-type: none"> Patient blood samples for cross-matching are securely identified with two unique identifiers.

Scoring:

- If the hospital ensures that patient blood samples for cross-matching are securely identified with two unique identifiers, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a cross-matching policies and procedures document, score is not met.

C.3.2.1 The hospital complies with guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids.**Measurable elements:**

- Guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids.
- Training records of staff trained in guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids.
- Process to measure compliance with guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids. • Training records of staff trained in guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids. • Reports that include measuring compliance with guidelines on safe and appropriate prescribing of blood and blood products.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conforms to guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids?
Observation	<ul style="list-style-type: none"> • Guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids.

Scoring:

- If the hospital conforms to guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have guidelines on safe and appropriate prescribing of blood and blood products, score is not met.

C.3.2.2 The hospital has policies and procedures for post-blood transfusion incident management.

Measurable elements:

- Policy for post-blood transfusion incident management.
- Training records of staff trained in policies and procedures for post-blood transfusion incident management.
- Process to measure compliance with policies and procedures for post-blood transfusion incident management.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for post-blood transfusion incident management. • Training records of staff trained in policies and procedures for post-blood transfusion incident management. • Reports that include measuring compliance with policies and procedures for post-blood transfusion incident management.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital implements policies and procedures for post-blood exposure incident management?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital conforms to guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have guidelines on safe and appropriate prescribing of blood and blood products, score is not met.

C.4	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has a safe medication system	Critical criteria	C.4.1.1 A licenced pharmacist provides a medication management system that addresses patient needs, meets applicable regulations and adheres to WHO guidelines.	<ul style="list-style-type: none"> • Job description of clinical pharmacist. • Medication safety programme.
		C.4.1.2 The hospital keeps high concentrations of electrolytes in a safe place.	Policies and procedures for removal of high concentrations of electrolytes, including potassium chloride, potassium phosphate and sodium chloride, from inpatient departments and storage in a safe place.
		C.4.1.3 The hospital ensures availability of life-saving medications at all times.	Life-saving medications based on needs of each department.
	Core criteria	C.4.2.1 The hospital ensures legible handwriting when prescribing or writing physicians' orders.	Policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders.
		C.4.2.2 The hospital ensures medication reconciliation at admission, transfer and discharge.	Safe medication policies and procedures that cover: <ul style="list-style-type: none"> ○ all transitions of care ○ clinical pharmacist job description ○ discharge planning ○ polypharmacy and de-prescribing.
		C.4.2.3 The hospital ensures patient (or carer) education about medication at discharge.	<ul style="list-style-type: none"> • Process to educate patients and their carers about efficient safe use of medication, any expected side-effects, potential interaction with other drugs and/or food, and pain management. • Medical records that reveal patient (or carer) education about medication at discharge. • Policies and procedures for patient (or carer) education about medication at discharge.
		C.4.2.4 The hospital standardizes and limits the number of medication concentrations.	<ul style="list-style-type: none"> • Safe medication policies and procedures that cover: selection and procurement; storage of medication; ordering and transcribing; preparing and dispensing; and administration and follow-up. • Special emphasis on: <ul style="list-style-type: none"> ○ labelling and storage of high-risk medications, such as potassium chloride, heparin and insulin. ○ Labelling and storage of look-alike, sound-alike medications. ○ Disposal of unused or expired medications. • Specific procedures for areas of high risk, such as oncology and anaesthesia. • Process to standardize and limit the number of medication concentrations throughout the hospital.
		C.4.2.5 The hospital has a pain management system and controls, access to and storage of narcotic products according to legislation.	Policy on controlled substances.
		C.4.2.6 The hospital has an implemented policy and procedures to manage medication errors.	Policy and procedures to manage medication errors.
		C.4.3.1 The hospital has clinical pharmacists who participate in medication orders and a system to identify drug–drug and drug–food interactions.	<ul style="list-style-type: none"> • Process for review of medications prescribed and an alarm system for drug–drug and drug–food interactions, and suggesting alternatives in case of interactions. • Clinical pharmacy policies and procedures to identify drug–drug and drug–food interactions.

C.4.1.1 A licenced pharmacist provides a medication management system that addresses patient needs, meets applicable regulations and adheres to WHO guidelines.

Measurable elements:

- Documents that show adherence of the hospital to WHO guidelines for medication safety and medication management system.
- Terms of reference for a licenced pharmacist who is directly involved in the medication management system within the hospital to ensure safety.
- Monitoring reports that show patients' needs in terms of medications and how that is reflected into the management system.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Job description and terms of reference for a licensed pharmacist who is directly involved in medication management within the hospital. • Random sample of records to reveal role of the clinical pharmacist in ensuring proper medication management system in the hospital. • Regular monitoring reports that ensure adherence to WHO guidelines and meeting the patients' needs in terms of medications.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there a licensed pharmacist who is involved in the medication management system in the hospital?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has a licensed pharmacist who is involved in the medication management system and ensures compliance with WHO guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the medication management system does not involve responsible pharmacist as part of the management team, score is not met.

C.4.1.2 The hospital keeps high concentrations of electrolytes in a safe place.

Measurable elements:

- Policies and procedures for removal of high concentrations of electrolytes, including potassium chloride, potassium phosphate and sodium chloride, from inpatient departments and storage in a safe place.
- Training records of staff trained in policies and procedures for removal of high concentrations of electrolytes and storage in a safe place.

- Process to measure compliance with policies and procedures for removal of high concentrations of electrolytes and storage in a safe place.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for removal of high concentrations of electrolytes from inpatient departments and storage in a safe place. • Training records of staff trained in policies and procedures for removal of high concentrations of electrolytes and storage in a safe place. • Reports that include measuring compliance with policies and procedures for removal of high concentrations of electrolytes and storage in a safe place.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital removes high concentrations of electrolytes, including potassium chloride, potassium phosphate and sodium chloride from inpatient departments and stores them in a safe place?
Observation	<ul style="list-style-type: none"> • High concentrations of electrolytes, including potassium chloride, potassium phosphate and sodium chloride, are absent from inpatient departments.

Scoring:

- If the hospital removes high concentrations of electrolytes, including potassium chloride, potassium phosphate and sodium chloride, from inpatient departments, and stores them in a safe place, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not remove high concentrations of electrolytes, including potassium chloride, potassium phosphate and sodium chloride, from inpatient departments, score is not met.

C.4.1.3 The hospital ensures availability of life-saving medications at all times.

Measurable elements:

- Life-saving medications based on needs of each department.
- Policies and procedures for life-saving medications.
- Training records of staff trained in policies and procedures for life-saving medications.
- Process to measure compliance with policies and procedures for life-saving medications.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Life-saving medications based on needs of each department. • Policies and procedures for life-saving medications. • Training records of staff trained in policies and procedures for life-saving medications. • Reports that include measuring compliance with policies and procedures for life-saving medications.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that hospital ensures availability of life-saving medications at all times?
<p>Observation</p>	<ul style="list-style-type: none"> • Life-saving medications based on needs of each department.

Scoring:

- If the hospital ensures availability of life-saving medications at all times through an implemented policy, and has evidence of continuous monitoring, score is fully met;
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure availability of life-saving medications at all times through an implemented policy, and has no evidence of continuous monitoring, score is not met.

C.4.2.1 The hospital ensures legible handwriting when prescribing or writing physicians' orders.

Measurable elements:

- Policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders.
- Training records of staff trained in policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders.
- Process to measure compliance with policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders. • Training records of staff trained in policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders. • Reports that include measuring compliance with policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders. • Random sample of medical records for the review of the compliance with policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital monitors and ensures legible handwriting when prescribing or writing physicians' orders?
<p>Observation</p>	<ul style="list-style-type: none"> • Medical records review of compliance with policies and procedures to ensure legible handwriting when prescribing or writing physicians' orders.

Scoring:

- If the hospital ensures legible handwriting when prescribing or writing physicians' orders, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure legible handwriting when prescribing or writing physicians' orders, score is not met.

C.4.2.2 The hospital ensures medication reconciliation at admission, transfer and discharge.

Measurable elements:

- Process for standard operating practice for medication reconciliation throughout the hospital.
- Training records of staff trained in policies and procedures for medication reconciliation.
- Process to measure compliance with policies and procedures for medication reconciliation.
- Process for medication reconciliation at admission.
- Process for medication reconciliation at transfer and/or discharge.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Standard operating practice for medication reconciliation. • Training records of staff trained in policies and procedures for medication reconciliation. • Reports that include measuring compliance with policies and procedures for medication reconciliation. • Random sample of medical records to review medication reconciliation at admission. • Random sample of medical records to review medication reconciliation at transfer and/or discharge.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital ensures medication reconciliation at admission, transfer and discharge?
<p>Observation</p>	<ul style="list-style-type: none"> • Medication reconciliation at admission. • Medication reconciliation at transfer and/or discharge.

Scoring:

- If the hospital implements and monitors medication reconciliation at admission and discharge, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not implement medicine reconciliation at admission and discharge, score is not met.

C.4.2.3 The hospital ensures patient (or carer) education about medication at discharge.

Measurable elements:

- Process to educate patients and their carers about efficient safe use of medication, any expected side-effects, potential interaction with other drugs and/or food, and pain management.
- Medical records that reveal patient (or carer) education about medication at discharge.
- Policies and procedures for patient (or carer) education about medication at discharge.
- Training records of staff trained in policies and procedures for patient (or carer) education about medication at discharge.
- Process to measure compliance with policies and procedures for patient (or carer) education about medication at discharge.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Policies and procedures for patient (or carer) education about medication at discharge. • Training records of staff trained in policies and procedures for patient (or carer) education about medication at discharge. • Reports that include measuring compliance with policies and procedures for patient (or carer) education about medication at discharge. • Random sample of closed medical records to review patient (or carer) education about medication at discharge.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital ensures patient (or carer) education about medication at discharge?
<p>Observation</p>	<ul style="list-style-type: none"> • Patient (or carer) education about medication at discharge.

Scoring:

- If the hospital ensures patient (or carer) education about medication at discharge, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure patient (or carer) education about medication at discharge, score is not met.

C.4.2.4 The hospital standardizes and limits the number of medication concentrations.

Measurable elements:

- Process to standardize and limit the number of medication concentrations throughout the hospital.
- Policies and procedures to standardize and limit the number of medication concentrations.
- Training records of staff trained in policies and procedures to standardize and limit the number of medication concentrations.
- Process to measure compliance with policies and procedures to standardize and limit the number of medication concentrations.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures to standardize and limit the number of medication concentrations. • Training records of staff trained in policies and procedures to standardize and limit the number of medication concentrations. • Reports that include measuring compliance with policies and procedures to standardize and limit the number of medication concentrations.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital standardizes and limits the use of several concentrations of medications?
Observation	<ul style="list-style-type: none"> • Compliance with policies and procedures to standardize and limit the number of medication concentrations.

Scoring:

- If the hospital standardizes and limits the use of several concentrations of medication concentration, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not standardize and limit the use of several concentrations of medication concentration, score is not met.

C.4.2.5 The hospital has a pain management system and controls access to and storage of narcotic products according to legislation.

Measurable elements:

- Process to assess and manage pain at initial assessment and on an ongoing basis.
- Pain management policies and procedures.
- Process for control of access to and storage of narcotic and scheduled products.
- Training records of staff trained in pain management policies and procedures.
- Process to measure compliance with pain management policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Pain management policies and procedures for the management, handling, prescribing and proper storage of narcotic and scheduled products. • Training records of staff trained in pain management policies and procedures. • Reports that include measuring compliance with pain management policies and procedures. • Random sample of medical records to review assessment of pain scale and management. • Login book or registration system of handling and use of narcotics.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has a pain management system and limits the availability of narcotic and scheduled products at inpatient departments?
Observation	<ul style="list-style-type: none"> • Compliance with pain management and storage of narcotics to ensure safety.

Scoring:

- If the hospital has a pain management system and controls access to narcotic products in inpatient departments, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a pain management system and does not control access to narcotic products in inpatient departments, score is not met.

C.4.2.6 The hospital has an implemented policy and procedures to manage medication errors.**Measurable elements:**

- The hospital establishes a definition for a medication error and near miss.
- Policy and procedures to manage medication errors.
- The hospital establishes and implements a process for reporting and acting on medication errors and near misses.
- Training records of staff trained in policy and procedures to manage medication errors.
- Process to measure compliance with policy and procedures to manage medication errors policy and procedures.
- Improvements are implemented based on reporting information and investigations done to be sent to relevant staff to improve medication use processes.
- Accountable relevant staff to act on reports and investigations are identified.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policy and procedures to manage medication errors. • Training records of staff trained in policy and procedures to manage medication errors. • Reports that include measuring compliance with policies and procedures to manage medication errors. • Reports of lessons learned from medication errors analysed.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has an implemented policy and procedures to manage medication errors?
Observation	<ul style="list-style-type: none"> • Medication errors reporting system.

Scoring:

- If the hospital has an implemented and monitored policy to manage medication errors, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not standardize and limit the use of several concentrations of medication concentration, score is not met.

C.4.3.1 The hospital has clinical pharmacists who participate in medication orders and a system to identify drug–drug and drug–food interactions.

Measurable elements:

- Process for review of medications prescribed and an alarm system for drug–drug and drug–food interactions, and suggesting alternatives in case of interactions.
- Clinical pharmacy policies and procedures to identify drug–drug and drug–food interactions.
- Training records of staff trained in clinical pharmacy policies and procedures to identify drug–drug and drug–food interactions.
- Process to measure compliance with clinical pharmacy policies and procedures to identify drug–drug and drug–food interactions.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Clinical pharmacy policy and procedures to identify drug–drug and drug–food interactions. • Training records of staff trained in clinical pharmacy policy and procedures to identify drug–drug and drug–food interactions. • Reports that include measuring compliance with clinical pharmacy policy and procedures to identify drug–drug and drug–food interactions. • Random sample of medical records to reveal role of clinical pharmacy.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that clinical pharmacists participate in medication orders and of a system to identify drug–drug and drug–food interactions?
Observation	<ul style="list-style-type: none"> • System to identify drug–drug and drug–food interactions.

Scoring:

- If the hospital has clinical pharmacists that participate in medication orders, and a system to identify drug–drug and drug–food interactions, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital has clinical pharmacists that participate in medication orders, and a system to identify drug–drug and drug–food interactions, score is not met.

Domain D: Safe environment

Domain	Standard statement	Number of criteria		
		Critical	Core	Developmental
D. Safe environment standards	D.1 The hospital has a safe and secure physical environment for patients, staff, volunteers and visitors.	0	15	1
	D.2 The hospital has a safe waste management system.	1	5	0
	Total	1	20	1

D.1	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has a safe and secure physical environment for patients, staff, volunteers and visitors	Core criteria	D.1.2.1 The hospital has a designated person in charge of environmental safety with the support of a multidisciplinary committee.	<ul style="list-style-type: none"> Organization structure. Terms of reference for the multidisciplinary environmental safety committee.
		D.1.2.2 The hospital design is maximized to provide a safe environment, including for infection control and the segregation of clean and dirty spaces.	Tour of the environment (see Section 3).
		D.1.2.3 The hospital has a preventive maintenance programme for its medical equipment and the physical environment.	<ul style="list-style-type: none"> Minutes of meetings of the multidisciplinary environmental safety committee. Records of the preventive maintenance programme for physical environment. Policies and procedures for building safety.
		D.1.2.4 The hospital implements a security programme and uses secure areas whenever appropriate.	Security policies and procedures in place and validated during hospital tour: <ul style="list-style-type: none"> ○ secure medical records ○ restricted access: intensive care unit (ICU), delivery unit, central sterile services department (CSSD), operating room (OR), hazardous areas ○ secure medication carts, medication rooms and pharmacies ○ CCTV ○ security personnel.
		D.1.2.5 The hospital ensures that staff display personal identification.	Policies and procedures with regard to staff wearing a visible identification badge and an appropriate uniform.
		D.1.2.6 The hospital develops and tests plans for internal and external emergencies.	<ul style="list-style-type: none"> Internal emergency plan. External emergency plan. Reports following drills of external and internal emergency plan.

D.1	Critical level	Critical statement	Guidance for evidence of compliance
The hospital has a safe and secure physical environment for patients, staff, volunteers and visitors	Core criteria	D.1.2.7 The hospital provides a monitoring system that alerts when critical services are at risk, such as electricity, water and medical gases.	<ul style="list-style-type: none"> • Tour of the environment (see Section 3).
		D.1.2.8 The hospital implements a fire safety programme with an evacuation plan.	<ul style="list-style-type: none"> • Fire safety policies and procedures. • Tour of the environment (see Section 3).
		D.1.2.9 The hospital has an effective utility system plan, including water, medical gases and fuel.	<ul style="list-style-type: none"> • Tour of the environment (see Section 3).
		D.1.2.10 The hospital has a radiation safety programme, including a designated responsible person.	<ul style="list-style-type: none"> • Designated person with responsibility for staff and patient safety during x-ray procedures. • Radiation safety policies and procedures. • Tour of the environment (see Section 3).
		D.1.2.11 The hospital displays warning signs marking unsafe areas.	<ul style="list-style-type: none"> • Tour of the environment (see Section 3).
		D.1.2.12 The hospital supplies appropriate and safe food and drinks for patients, staff and visitors.	Policies and procedures for: <ul style="list-style-type: none"> ○ supply of appropriate and safe food and drinks for patients, staff and visitors ○ segregation of clean and dirty spaces in kitchen and dining areas ○ infection control during the preparation, storage and distribution of food and beverages ○ availability of special diets according to disease and patient needs ○ employee screening and health certificates.
		D.1.2.13 The hospital maintains a clean environment.	<ul style="list-style-type: none"> • Housekeeping policies and procedures. • Tour of the environment (see Section 3).
		D.1.2.14 The hospital has an implemented smoke-free policy.	<ul style="list-style-type: none"> • Tour of the environment (see Section 3).
	D.1.2.15 The hospital provides mechanisms to ensure a backup supply of essential services, including medical gases, water and electricity.	<ul style="list-style-type: none"> • Uninterrupted power supply/generator, generator should start within 10 seconds of failure and be able to generate for two hours. • Backup water. • Supply of medical gases. 	
Developmental criterion	D.1.3.1 The hospital has an automated information management and electronic medical records system with an appropriate backup system.	<ul style="list-style-type: none"> • Policies on creation, management and control of electronic medical records. 	

D.1.2.1 The hospital has a designated person in charge of environmental safety with the support of a multidisciplinary committee.

Measurable elements:

- Notification letter for designated person with terms of reference (TORs).
- Notification letter of the multidisciplinary environmental safety committee.
- Terms of reference for the multidisciplinary environmental safety committee.
- Minutes of meetings of the multidisciplinary environmental safety committee.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Notification letter for designated person with terms of reference (TORs). • Notification letter of the multidisciplinary environmental safety committee. • Terms of reference for the multidisciplinary environmental safety committee. • Minutes of meetings of the multidisciplinary environmental safety committee.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has a multidisciplinary environmental safety committee?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital has a multidisciplinary environmental safety committee that meets on a regular basis, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a multidisciplinary environmental safety committee, score is not met.

D.1.2.2 The hospital design is maximized to provide a safe environment, including for infection control and the segregation of clean and dirty spaces.

Measurable elements:

- Compliance with national regulations, laws and hospital building code.
- In the absence of national regulations, laws and hospital building code:
 - o directive signs all around the hospital
 - o floors have no fall hazards (floors are slip-resistant, dry)
 - o floors comply with IPC measures (clean, good repair; e.g. no cracks, curved walls)

- o ceiling tiles comply with IPC measures (clean, good repair; e.g. no cracks, none missing)
- o bathrooms have grab bars
- o special needs patients have access to all departments and needs are met (bathrooms, slopes, etc.)
- o nurse call cords available, functioning and accessible to patients in bed and bathrooms
- o wheelchairs and stretchers clean, in good operating condition, and can access all areas
- o electric lights functioning (or need repair) and sufficient
- o safety electrical outlets are installed in paediatric areas
- o behavioural health areas secured with tamper-resistant screws
- o all potential points of attachment for suicide by strangulation designed to break away, e.g. curtain rods
- o separation of clean and dirty areas
- o fire safety specifications and exits
- o operating room and sterilization flow ensure separation of in and out
- o proper ventilation via air conditioning or cross-ventilation
- o ventilation has high efficiency particulate air (HEPA) filters and is regulated
- o appropriate sinks, e.g. in patient rooms, clinics and nurse stations
- o patient privacy ensured
- o patient spiritual and religious needs are met
- o construction sites sealed from dust, noise and vibration, and secured
- o positive pressure room, which is regulated.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Minutes of multidisciplinary environmental safety committee meetings. • Building blueprints.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital design is maximized to provide a safe environment, including for infection control?
<p>Observation</p>	<ul style="list-style-type: none"> • Compliance with national hospital building code, laws and regulations. • Hospital has directive signs all around the hospital. • Floors have no fall hazards (floors are slip-resistant, dry). • Floors comply with IPC measures (clean, good repair, e.g. no cracks, curved walls). • Ceilings tiles comply with IPC measures (clean, good repair, e.g. no cracks, none missing). • Bathrooms have grab bars. • Special needs patients can access all departments in the hospital and needs are met (bathrooms, slopes, etc.). • Nurse call cords available, functioning and accessible to patients in bed and bathrooms. • Wheelchairs and stretchers clean, in good operating condition and can access all areas. • Electric lights functioning (or need repair) and sufficient. • Safety electrical outlets are installed in paediatric areas. • Behavioural health areas secured with tamper-resistant screws. • All potential points of attachment for suicide by strangulation designed to break away, e.g. curtain rods. • Separation of clean and dirty areas. • Fire safety specifications and exits. • Operating room and sterilization flow ensures separation of way in and way out. • Proper ventilation via air conditioning or cross-ventilation. • Ventilation has high efficiency particulate air (HEPA) filters and is regulated. • Appropriate sinks, e.g. in patient rooms, clinics and nurse stations. • Patient privacy ensured. • Patient spiritual and religious needs are met. • Construction sites sealed from dust, noise and vibration, and secured. • Positive pressure room, which is regulated.

Scoring:

- If the hospital design provides a safe environment, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital design does not provide a safe environment, score is not met.

D.1.2.3 The hospital has a preventive maintenance programme for its medical equipment and the physical environment.

Measurable elements:

- Minutes of meetings of the multidisciplinary environmental safety committee.
- Records of preventive maintenance programme for physical environment.
- Policies and procedures for building safety.
- Training records of staff trained in building safety policies and procedures.
- Process to measure compliance with building safety policies and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Minutes of meetings of the multidisciplinary environmental safety committee. • Records of preventive maintenance programme for physical environment. • Policies and procedures for building safety. • Training records of staff trained in physical environment policies and procedures. • Reports that include measuring compliance with physical environment policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has a preventive maintenance programme for its physical environment?
Observation	<ul style="list-style-type: none"> • Actions that show the implementation of the programme.

Scoring:

- If the hospital has a preventive maintenance programme for its physical environment, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met; and
- If the hospital does not have a preventive maintenance programme for its physical environment, score is not met.

D.1.2.4 The hospital implements a security programme and uses secure areas whenever appropriate.

Measurable elements:

- Security policies and procedures.
- Training records of staff trained in security policy and procedures.
- Process to measure compliance with security policy and procedures.

- Secure medical records.
- Secure operating rooms.
- Secure intensive care units.
- Secure medication carts, medication rooms and pharmacies.
- Secure neonatal intensive care unit.
- Secure obstetrics department.
- Doors to hazardous areas and other secure areas locked when appropriate.
- Security of hazardous materials.
- Staff and visitors follow security procedures when entering and leaving sensitive areas.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Security policies and procedures. • Training records of staff trained in security policies and procedures. • Reports that include measuring compliance with security policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of an implemented security programme?
Observation	<ul style="list-style-type: none"> • Compliance with security policies and procedures. • Security cameras. • Security staff. • Secure medical records. • Secure operating rooms. • Secure intensive care units. • Secure neonatal intensive care unit. • Secure obstetrics department. • Secure medication carts, medication rooms and pharmacies. • Doors to hazardous areas and other secure areas locked when appropriate. • Hazardous materials properly labelled and stored. • Staff and visitors follow security procedures when entering and leaving sensitive areas.

Scoring:

- If the hospital has an implemented security programme, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have an implemented security programme, score is not met.

D.1.2.5 The hospital ensures that staff display personal identification.**Measurable elements:**

- Policies and procedures with regard to staff wearing a visible identification badge and an appropriate uniform.
- Training records of staff trained in personal identification policies and procedures.
- Process to measure compliance with personal identification policy and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures with regard to staff wearing a visible identification badge and an appropriate uniform. • Training records of staff trained in staff identification policies and procedures. • Reports that include measuring compliance with staff identification policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of staff displaying personal identification?
Observation	<ul style="list-style-type: none"> • Staff wearing a visible identification badge and an appropriate uniform.

Scoring:

- If the hospital ensures staff display personal identification, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not ensure that staff display personal identification, score is not met.

D.1.2.6 The hospital develops and tests plans for internal and external emergencies.**Measurable elements:**

- Internal emergency plan.
- External emergency plan.
- Process to measure rehearsal of internal and external emergency plans implementation.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Internal emergency plan. • External emergency plan. • Reports to measure internal and external emergency plan implementation.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital staff rehearse implementation of internal and external emergency plan? • What happens if there is an external emergency? • Is emergency response equipment in good repair and locked? • Are emergency supplies of medication and medical supplies secure and current? • Ask three staff: <ul style="list-style-type: none"> ○ What does the announcement of a Code Blue mean? ○ What does the announcement of a Code Pink mean? ○ Is emergency response equipment in good repair and locked? ○ Are emergency supplies of medication and medical supplies secure and current?
<p>Observation</p>	<ul style="list-style-type: none"> • Response to different emergency code information matrices posted at the nursing station or in a visible location in the department.

Scoring:

- If the hospital implements internal and external emergency plans, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital has neither external nor internal emergency plans, score is not met.

D.1.2.7 The hospital provides a monitoring system that alerts when critical services are at risk, such as electricity, water and medical gases.

Measurable elements:

- Monitoring policies for early identification of risks related to critical services.
- Policies and procedures for warning signs.
- Training records of staff trained in policies and procedures for how to respond and react to alerts related to critical services.
- Process to measure compliance with policies and procedures to respond to risks related to critical services.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures to respond to alerts related to critical services. • Training records of staff trained in policies and procedures for how to respond and react to alerts related to critical services. • Reports that include measuring compliance with policies and procedures for responding to alerts signs for critical services.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there a monitoring system that alerts when critical services are at risk? • Is the staff trained on responding to alerts of risks related to critical services and how to deal with that?
Observation	<ul style="list-style-type: none"> • Any system implemented for the monitoring of critical services.

Scoring:

- If the hospital demonstrates a special monitoring system to risks related to critical services, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not demonstrate policies to respond to critical services-related risk, score is not met.

D.1.2.8 The hospital implements a fire safety programme with an evacuation plan.

Measurable elements:

- Fire and smoke safety policies and procedures.
- Training records of staff trained in fire and smoke safety policies and procedures.
- Process to measure compliance with fire and smoke safety policies and procedures.
- Fire evacuation plan posted throughout the hospital.
- Fire extinguishers, alarms and evacuation system are in good repair.
- Exit signs lit.
- All exit doors are fire-resistant.
- Hospital has clear fire exits and stairways.
- All fire extinguishers have current labels dated and signed.
- Flammable liquids are stored securely in safe quantities.
- Valve protection cap is in place when oxygen cylinder is not in use.
- Full and empty oxygen cylinders stored separately in upright position.
- All cylinders stored in shade and correct temperature away from direct sunlight and heat sources.
- All compressed gas cylinders chained or safely secured.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Fire and smoke safety policies and procedures. • Training records of staff trained in fire and smoke safety policies and procedures. • Reports that include measuring compliance relevant fire and smoke safety policies and procedures.
<p>Interviews</p>	<ul style="list-style-type: none"> • What happens if there is a fire?
<p>Observation</p>	<ul style="list-style-type: none"> • Compliance with fire and smoke safety programme and evacuation plan. • Response to different emergency code information matrices posted at the nursing station or in a visible location in the department. • Fire evacuation plan posted throughout the hospital. • Fire extinguishers, alarms and evacuation system are in good repair. • Exit signs lit. • All exit doors are fire-resistant. • Hospital has clear fire exits and stairways. • All fire extinguishers have current labels dated and signed. • Flammable liquids are stored securely in safe quantities. • Valve protection cap is in place when oxygen cylinder is not in use. • Full and empty oxygen cylinders stored separately in upright position. • All cylinders stored in shade and at correct temperature away from direct sunlight and heat sources. • All compressed gas cylinders chained or safely secured.

Scoring:

- If the hospital implements a fire and smoke safety programme with an evacuation plan, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have a fire and smoke safety programme with an evacuation plan, score is not met.

D.1.2.9 The hospital has an effective utility system plan, including water, medical gases and fuel.

Measurable elements:

- Utility system plan.
- Policies and procedures for preventive maintenance utility system.
- Backup of utility system plan in case of failure or interruption.
- Training of staff in policies and procedures for preventive maintenance utility system.
- Process to measure compliance with utility system policies and procedures and plans.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Utility system plan. • Policies and procedures for a preventive maintenance utility system. • Backup of the utility system plan in case of failure or interruption. • Training of staff in utility system plans and policies and procedures. • Reports that include measuring compliance with utility system policies and procedures and plans.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of an effective utility system plan? Does it include: water, medical gases, fuel, communication systems, preventive maintenance and a backup plan in case of failure or interruption?
Observation	<ul style="list-style-type: none"> • Compliance with the utility system plan and policies and procedures.

Scoring:

- If the hospital has an effective utility system plan, including water, medical gases, fuel, communication systems, preventive maintenance and a backup plan in case of failure or interruption, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have an effective utility system plan, score is not met.

D.1.2.10 The hospital a radiation safety programme, including a designated responsible person.**Measurable elements:**

- Notification letter for designated responsible person with terms of reference (TORs).
- Radiation safety policies and procedures.
- Training and ongoing education records of radiology and diagnostic imaging staff trained in radiation safety policy and procedures.
- Safety protective equipment and devices appropriate to the practices and hazards related to radiation and diagnostic imaging are available to staff, patients and visitors, and in the area in which radiology and diagnostic imaging services are provided.
- Process to measure compliance with radiation safety policy and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Notification letter for designated responsible person with terms of reference (TORs). • Radiation safety policies and procedures. • Training and ongoing education records of radiology and diagnostic imaging staff trained in radiation safety policy and procedures. • List of safety protective equipment available to staff, patients and visitors, and their placement in the area in which radiology and diagnostic imaging services are provided. • Reports that include measuring compliance with radiation safety policy and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of radiation safety programme?
Observation	<ul style="list-style-type: none"> • Compliance with radiation safety programme. • Staff wear radiation dosimeters. • Staff wear radiation safety apron with no cracks and in good repair.

Scoring:

- If the hospital demonstrates a radiation safety programme, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not demonstrate a radiation safety programme, score is not met.

D.1.2.11 The hospital displays warning signs marking unsafe areas.

Measurable elements:

- Policies and procedures for warning signs, including identification of safety zones and access restriction.
- Training records of staff trained in policies and procedures for warning signs.
- Process to measure compliance with policies and procedures for warning signs.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for warning signs, including identification of safety zones and access restriction. • Training records of staff trained in policies and procedures for warning signs. • Reports that include measuring compliance with policies and procedures for warning signs.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital displays warning signs marking unsafe areas?
Observation	<ul style="list-style-type: none"> • Warning signs marking unsafe areas. Include if appropriate: electricity box, radiation, radioactive substances, construction.

Scoring:

- If the hospital demonstrates warning signs marking unsafe areas, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not demonstrate warning signs marking unsafe areas, score is not met.

D.1.2.12 The hospital supplies appropriate and safe food and drinks for patients, staff and visitors.**Measurable elements:**

- Compliance with national laws and regulations.
- Policies and procedures for appropriate and safe food and drinks for patients, staff and visitors.
- Policies and procedures for safe kitchen programmes.
- Special diets according to disease and patient needs.
- Training records of staff trained in relevant policies and procedures.
- Process to measure compliance with policies and procedures for safe food and drink.
- Employee screening and health certificates.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • National laws and regulations for food and drink safety. • Policies and procedures for appropriate and safe food and drinks for patients, staff and visitors. • Training records of staff trained in relevant policy and procedures. • Policies and procedures for safe kitchen programmes. • Special diets according to disease and patient needs. • Reports that include measuring compliance with relevant policy and procedures. • Employee screening and health certificates.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital supplies appropriate and safe food and drink for patients, staff and visitors?
Observation	<ul style="list-style-type: none"> • Compliance with safe food and drink. • Separation of vegetables and fruits from meat and poultry. • Control of temperature of refrigerator. • Separation of cooked and raw food. • Kitchen safety programme. • Personal protective equipment of staff.

Scoring:

- If the hospital supplies appropriate and safe food and drink for patients, staff and visitors, score is fully met.

- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not supply appropriate and safe food and drink for patients, staff and visitors, score is not met.

D.1.2.13 The hospital maintains a clean environment.

Measurable elements:

- Housekeeping policies and procedures.
- Training records of staff trained in housekeeping policy and procedures.
- Process to measure compliance with housekeeping policy and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Housekeeping policies and procedures. • Training records of staff trained in housekeeping policies and procedures. • Reports that include measuring compliance with housekeeping policies and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital maintains a clean environment?
Observation	<ul style="list-style-type: none"> • Compliance with clean environment standards. • Surfaces, separation of clean and dirty linen, general cleanliness.

Scoring:

- If the hospital maintains a clean environment, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not maintain a clean environment, score is not met.

D.1.2.14 The hospital has an implemented smoke-free policy.

Measurable elements:

- Smoke-free policy.
- Training records of staff trained in smoke-free policy and procedures.
- Process to measure compliance with smoke-free policy and procedures.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Smoke-free policy. • Training records of staff trained in smoke-free policy and procedures. • Reports that include measuring compliance with smoke-free policy and procedures.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has implemented a smoke-free policy?
Observation	<ul style="list-style-type: none"> • Compliance with smoke-free policy.

Scoring:

- If the hospital implements a smoke-free policy, score is fully met.
- If the hospital has a smoke-free policy, with no evidence of full implementation, score is partially met.
- If the hospital does not have a smoke-free policy, score is not met.

D.1.2.15 The hospital provides mechanisms to ensure a backup supply of essential services, including medical gases, water and electricity.

Measurable elements:

- Policies and procedures to support as a backup supply for essential services.
- Availability of uninterrupted power supply/generator; generator should start within 10 seconds of failure and be able to generate for two hours.
- Backup water supply.
- Backup supply for medical gases.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures to support as a backup supply for essential services. • Emergency steps to overcome any issues encountered in the major supplies for essential services, including electricity, water and gas.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is it clear how to activate/use the backup supplies for essential services, if needed?
Observation	<ul style="list-style-type: none"> • Availability of uninterrupted power supply/generator; generator should start within 10 seconds of failure and be able to generate for two hours. • Backup water supply. • Backup supply for medical gases.

Scoring:

- If the hospital has a backup system and elements for essential services, score is fully met.
- If the hospital has an unclear system or partial supplies for essential services, score is partially met.
- If the hospital does not have a backup system for essential services, score is not met.

D.1.3.1 The hospital has an automated information management and electronic medical records system with an appropriate backup system.**Measurable elements:**

- Automated information management and electronic medical records system with an appropriate backup system.
- Policies and procedures for information management and electronic medical records.
- Training records of staff trained in policies and procedures for information management and electronic medical records.
- Process to measure compliance with policies and procedures for relevant information management and electronic medical records.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for information management and electronic medical records. • Training records of staff trained in policies and procedures for information management and electronic medical records. • Reports that include measuring compliance with policies and procedures for information management and electronic medical records.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital has an automated information management and electronic medical records system with an appropriate backup system?
Observation	<ul style="list-style-type: none"> • Automated information management and electronic medical records system with an appropriate backup system.

Scoring:

- If the hospital has an automated information management and electronic medical records system with an appropriate backup system, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not have an automated information management and electronic medical system records with an appropriate backup system, score is not met.

D.2	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital has a safe waste management system	Critical criterion	D.2.1.1 The hospital conforms to guidelines on management of sharps waste.	Guidelines (including WHO guidelines) on management of sharps waste.
	Core criteria	D.2.2.1 The hospital conforms to guidelines on safe waste management, including safe storage and disposal of waste.	Guidelines (including WHO guidelines) on safe management of wastes from health care activities.
		D.2.2.2 The hospital conforms to guidelines on management of biological waste.	Guidelines (including WHO guidelines) on management of biological waste.
		D.2.2.3 The hospital conforms to guidelines on management of chemical waste.	Guidelines (including WHO guidelines) on management of chemical waste.
		D.2.2.4 The hospital conforms to guidelines on management of radiological waste.	Guidelines (including WHO guidelines) on management of radiological waste.
		D.2.2.5 The hospital segregates waste according to hazard level and colour codes it.	Policies and procedures for waste segregation according to hazard level and colour coding it.

D.2.1.1 The hospital conforms to guidelines on management of sharps waste.

Measurable elements:

- Guidelines (including WHO guidelines) on management of sharps waste.
- Training records of staff trained in guidelines on management of sharps waste.
- Process to measure compliance with guidelines on management of sharps waste.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Guidelines (including WHO guidelines) on management of sharps waste. • Training records of staff trained in guidelines on management of sharps waste. • Process to measure compliance with relevant guidelines on management of sharps waste.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conforms to guidelines on management of sharps, including WHO guidelines?
Observation	<ul style="list-style-type: none"> • Sharps disposal in safety box.

Scoring:

- If the hospital conforms to guidelines on management of sharps, including WHO guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conform to guidelines on management of sharps, including WHO guidelines, score is not met.

D.2.2.1 The hospital conforms to guidelines on safe waste management, including safe storage and disposal of waste.**Measurable elements:**

- Guidelines (including WHO guidelines) on safe storage and safe management of wastes from health care activities.
- Training records of staff trained in guidelines on safe waste management.
- Process to measure compliance with guidelines on safe waste management.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Guidelines (including WHO guidelines) on safe management of wastes from health care activities. • Training records of staff trained in guidelines on safe waste management. • Reports that include measuring compliance with guidelines on safe waste management.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conforms to guidelines on safe management of waste from health care activities?
Observation	<ul style="list-style-type: none"> • Compliance with waste management guidelines.

Scoring:

- If the hospital conforms to guidelines on safe management of waste from health care activities, including WHO guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conform to guidelines on safe management of waste from health care activities, score is not met.

D.2.2.2 The hospital conforms to guidelines on management of biological waste.**Measurable elements:**

- Guidelines (including WHO guidelines) on management of biological waste.
- Training records of staff trained in guidelines on biological waste management.
- Process to measure compliance with guidelines on biological waste management.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Guidelines (including WHO guidelines) on management of biological waste management. • Training records of staff trained in guidelines on biological waste management. • Reports that include measuring compliance with guidelines on biological waste management.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conforms to guidelines on management of biological waste?
Observation	<ul style="list-style-type: none"> • Compliance with biological waste management guidelines.

Scoring:

- If the hospital conforms to guidelines on management of biological waste, including WHO guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conform to guidelines on management of biological waste, score is not met.

D.2.2.3 The hospital conforms to guidelines on management of chemical waste.**Measurable elements:**

- Guidelines (including WHO guidelines) on management of chemical waste.
- Training records of staff trained in guidelines on chemical waste management.
- Process to measure compliance with guidelines on chemical waste management.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Guidelines (including WHO guidelines) on management of chemical waste. • Training records of staff trained in guidelines on chemical waste management. • Reports include measuring compliance with guidelines on chemical waste management.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conforms to guidelines on management of chemical waste?
Observation	<ul style="list-style-type: none"> • Compliance with chemical waste management guidelines.

Scoring:

- If the hospital conforms to guidelines on management of chemical waste, including WHO guidelines, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conform to guidelines on management of chemical waste, score is not met.

D.2.2.4 The hospital conforms to guidelines on management of radiological waste.**Measurable elements:**

- Guidelines (including WHO guidelines) on management of radiological waste.
- Training records of staff trained in guidelines on management of radiological waste.
- Process to measure compliance with guidelines on management of radiological waste.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Guidelines (including WHO guidelines) on management of radiological waste. • Training records of staff trained in guidelines on radiological waste management. • Reports that include measuring compliance with guidelines on radiological waste management.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conforms to guidelines (including WHO guidelines) on management of radiological waste?
Observation	<ul style="list-style-type: none"> • Compliance with radiological waste management guidelines.

Scoring:

- If the hospital conforms to guidelines on management of radiological waste, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conform to guidelines on management of radiological waste, score is not met.

D.2.2.5 The hospital segregates waste according to hazard level and colour codes it.**Measurable elements:**

- Policies and procedures for waste segregation according to hazard level and colour coding it (recommended actions are available at https://www.who.int/water_sanitation_health/publications/wastemanag/en).
- Training records of staff trained in policies and procedures for waste segregation.
- Process to measure compliance with policies and procedures for waste segregation.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for waste segregation according to hazard level (see guidelines) and colour coding it. • Training records of staff trained in policies and procedures for waste segregation. • Reports that include measuring compliance with policies and procedures for waste segregation.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of waste segregation according to hazard level (see guidelines) and colour coding it?
Observation	<ul style="list-style-type: none"> • Waste segregation according to hazard level (see guidelines) and colour coding it.

Scoring:

- If the hospital segregates waste according to hazard level and colour codes it, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not segregate waste according to hazard level and does not colour code it, score is not met.

Domain E: Life-long learning

Domain	Standard statement	Number of criteria		
		Critical	Core	Developmental
E. Life-long learning standards	E.1 The hospital has a staff professional development programme with patient safety as a cross-cutting theme.	1	1	0
	E.2 The hospital conducts research and quality improvement projects in patient safety on an ongoing basis.	0	1	2
	Total	1	2	2

E.1	Criteria level	Criteria statement	Evidence of compliance
The hospital has a staff professional development programme with patient safety as a cross-cutting theme	Critical criterion	E.1.1.1 All hospital staff are provided with a patient safety orientation programme.	Patient safety orientation to include: <ul style="list-style-type: none"> ○ fire safety ○ manual handling ○ hand hygiene ○ IPC ○ risk management and use of reporting system ○ needle stick.
	Core criterion	E.1.2.1 The hospital provides ongoing training and education for all staff to ensure safe patient care and staff respect patient rights.	Process to: <ul style="list-style-type: none"> ○ ensure identification of staff training needs and addressing these needs by ongoing training for all staff to ensure safe patient care and respecting patient rights ○ refresher training for topics covered in orientation programme.

E.1.1.1 All hospital staff are provided with a patient safety orientation programme.

Measurable elements:

- Patient safety orientation programme, for example, policies and procedures, and guidelines.
- Process to train staff on use of scientific research tools to address patient safety problems, e.g. the Global Trigger Tool for Measuring Adverse Events from the Institute for Healthcare Improvement.
- Training records of staff trained in scientific research tools and retrospective and prospective methods to address patient safety problems.
- Training records of staff trained in patient safety during orientation programme.
- Process to measure compliance with patient safety orientation programme.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Patient safety orientation programme. • Training records of staff trained in patient safety during orientation programme. • Reports that include measuring compliance with patient safety orientation programme. • Personnel files that contain evidence of orientation to patient safety.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that all hospital staff are provided with a patient safety orientation programme?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If 80–100% of hospital staff are provided with a patient safety orientation programme, score is fully met.
- If 60–79% of hospital staff are provided with a patient safety orientation programme, score is partially met.
- If <60% of hospital staff are provided with a patient safety orientation programme, score is not met.

E.1.2.1 The hospital provides ongoing training and education for all staff to ensure safe patient care and staff respect patient rights.**Measurable elements:**

- Process to ensure identification of staff training needs and addressing these needs by ongoing training for all staff to ensure safe patient care.
- Process to train staff in use of scientific research tools to address patient safety problems, e.g. Institute for Healthcare Improvement global medication safety tool for measuring adverse events.
- Training records of staff trained in scientific research tools and retrospective and prospective methods to address patient safety problems.
- Training records of staff trained in safe patient care practices based on their individual training needs.
- Training records of staff trained in aspects of patient rights and how to respect these.
- Process to measure compliance with ongoing training for all staff to ensure safe patient care standards.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

<p>Documents to be reviewed</p>	<ul style="list-style-type: none"> • Training records of staff trained in scientific research tools and retrospective and prospective methods to address patient safety problems. • Training records of staff trained in safe patient care practices based on their individual training needs. • Reports that include measuring compliance with ongoing training for all staff to ensure safe patient care standards. • Training records of staff trained in aspects of patient rights and how to respect these.
<p>Interviews</p>	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital promotes ongoing training for all staff to ensure safe patient care? • Relevant staff: Is there evidence that the hospital promotes ongoing training for all staff to ensure staff respects patient rights?
<p>Observation</p>	<ul style="list-style-type: none"> • Practices related to protecting patient rights.

Scoring:

- If the hospital promotes ongoing training for 80–100% of staff to ensure safe patient care, score is fully met.
- If the hospital promotes ongoing training for 60–79% of staff to ensure safe patient care, score is partially met.
- If the hospital promotes ongoing training for <60% of staff to ensure safe patient care, score is not met.

E.2	Criteria level	Criteria statement	Guidance for evidence of compliance
The hospital conducts research and quality improvement projects in patient safety on an ongoing basis	Core criterion	E.2.2.1 All research is approved and monitored by the patient safety internal body or other committee according to the needs of the hospital.	Terms of reference for the research ethics committee.
	Developmental criteria	E.2.3.1 The hospital conducts prospective, retrospective, and/or cross-sectional studies to assess the magnitude and nature of adverse events to improve the safety of care, on an annual basis.	Prospective, retrospective and cross-sectional studies and reports using who methodology to assess the magnitude and nature of adverse events to ensure safer care, conducted at least on an annual basis.
		E.2.3.2 The hospital conducts quality improvement projects to promote patient safety activities.	<ul style="list-style-type: none"> • Process to train staff on the use of quality improvement tools, e.g. Plan-Do-Study-Act (PDSA). • Evidence of quality improvement projects.

E.2.2.1 All research is approved and monitored by the patient safety internal body or other committee according to the needs of the hospital.

Measurable elements:

- Policies and procedures for patient safety research.
- Training records of staff trained in policies and procedures for patient safety research.
- Process to measure compliance with policies and procedures for patient safety research.
- Minutes of meetings of the patient safety internal body or relevant committee.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Policies and procedures for patient safety research. • Training records of staff trained in policies and procedures for patient safety research. • Reports that include measuring compliance with policies and procedures for patient safety research. • Minutes of meetings of the patient safety internal body or relevant committee.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that all patient safety research is approved and monitored by the patient safety internal body according to the needs of the hospital?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If all patient safety research is approved and monitored by the patient safety internal body according to the needs of the hospital, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If all patient safety research is neither approved nor monitored by the patient safety internal body according to the needs of the hospital, score is not met.

E.2.3.1 The hospital conducts prospective, retrospective, and/or cross-sectional studies to assess the magnitude and nature of adverse events to improve the safety of care, on an annual basis.

Measurable elements:

- Prospective, retrospective, and/or cross-sectional studies and reports using WHO methodology to assess the magnitude and nature of adverse events to ensure safer care, conducted on a regular basis at least once a year.
- WHO methodological guide to document patient harm.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Prospective, retrospective, and/or cross-sectional studies and reports to assess the magnitude and nature of adverse events to ensure safer care, conducted on an annual basis.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence that the hospital conducts prospective studies on a regular basis to assess the magnitude and nature of adverse events to ensure safer care?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital conducts prospective, retrospective, and/or cross-sectional studies on an annual basis to assess the magnitude and nature of adverse events, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If the hospital does not conduct prospective studies to assess magnitude and nature of adverse events, score is not met.

E.2.3.2 The hospital conducts quality improvement projects to promote patient safety activities.

Measurable elements:

- Records of planning, implementing, monitoring, and evaluating quality improvement projects that promote patient safety.

- Training records of staff trained in implementing quality improvement projects and patient safety activities.
- Monitoring reports of applying scalable and sustainable quality improvement projects.

Evaluation process:

- Review the documents listed for the survey process.
- Confirm data through interviews.
- Read through the scoring guidelines.

Survey process

Documents to be reviewed	<ul style="list-style-type: none"> • Records of planning, implementing, monitoring and evaluating quality improvement projects that promote patient safety. • Training records of staff trained in implementing quality improvement projects and patient safety activities. • Monitoring reports of applying scalable and sustainable quality improvement projects.
Interviews	<ul style="list-style-type: none"> • Relevant staff: Is there evidence of applying quality improvement projects that promote for patient safety?
Observation	<ul style="list-style-type: none"> • Not applicable.

Scoring:

- If the hospital implements quality improvement projects that target patient safety, score is fully met.
- If the hospital has partial compliance with measurable elements, score is partially met.
- If hospital does not consider patient safety as a target of some of its quality improvement projects, or does not have relevant projects at all, score is not met.

▶ Section 3. Patient Safety Friendly Hospital Framework (PSFHF) assessment tools

Section 3 assists the hospital and survey team in the collection of data through document reviews, observation and interviews. These assessment tools are not an exact science and offer suggestions to be followed.

Preamble

This section has been prepared to assist the hospital and survey team in the collection of data through document reviews, observation and interviews. These assessment tools are not an exact science and offer suggestions to be followed. Titles of documents can vary depending on the country, for example, an operational plan can also be called an annual plan. It is the responsibility of the peer review survey team to triangulate as much evidence as is required to fairly and consistently assess each criterion. It is the responsibility of the hospital to be transparent and provide useful documents and data that validate compliance to each criterion. It is suggested that the hospital present documents in a logical sequential manner for ease of use.

This section has four subsections: (A) brief information on the hospital; (B) document review: a list of key documents across the five domains; (C) guides to assist observation in high-risk departments; and (D) interview tools: these include several questionnaires that help gather specific information from hospital staff or patients during the assessment. The interview section also contains a proposed agenda for the assessment visit and a report template.

A. Hospital in brief

1. Hospital name:
2. List the types of medical services provided by the hospital:
3. Some statistics:
 - a. Number of inpatient beds (currently in operation):
 - b. Average daily inpatient census:
 - c. Annual ambulatory/outpatient visits:
 - d. Annual emergency room visits:
 - e. Annual number of births:
 - f. Length of stay:
 - g. Occupancy rate:
 - h. Mortality and morbidity:
4. List the top five medical discharge diagnoses and the top five surgical procedures performed:
5. List nonmedical services that support the hospital:
6. List any contracted (outsourced) services:
7. Do you operate ambulances?
8. Site description: list all buildings affiliated with the hospital:
9. Has there been any incident over the last 12 months that affected patient care that you would like to share with the peer review survey team?

B. List of documents

The following list of documents are organized into five groups to represent each domain. One document may cover a number of criteria, therefore, the list is not exhaustive. To help the survey team become familiar with the hospital being surveyed, the documents marked with * should be sent to the team two weeks before the visit is scheduled.

In general, all policies, procedures and guidelines must be evidence based, dated, signed off by a person in authority and circulation controlled. Evidence should be available for the distribution list, relevant training and how compliance is evaluated. They should all be available at the department level, either in soft or hard copy.

All documents should be dated and signed by the relevant authority. Documents are examined at the start of the survey and their use validated through interviews and observation tours. The Patient Safety Friendly Hospital Framework (PSFHF) is not intended to become over-bureaucratic with excessive documents, therefore, it is advised to focus on validating compliance to criteria by the use of data.

1. Domain A: Leadership and management

Document	Evidence to include
*Long term strategic plan	<ul style="list-style-type: none"> • Patient safety activity • Mission, vision and values statements
Short term operational plan and budget	<ul style="list-style-type: none"> • Annual goals • Funding for patient safety • Targets achieved
*Organization structure	Responsibility and reporting lines for all positions. At least one person identified in charge for each department or service in the hospital. The same person can be responsible for a number of services, i.e. infection control, risk management and patient safety.
Executive team walk-arounds	<ul style="list-style-type: none"> • Responsible person • Terms of reference for the walk-around team • Actions taken • Feedback to staff
Budget for patient safety	Either as part of another programme, e.g. infection control, staff training or as a standalone budget line.
Code of ethics	<ul style="list-style-type: none"> • Clinical decision support structure • Policy on resuscitation • Policy on research ethics
Process to assess patient safety culture	Either assessed by a validated tool (Agency for Healthcare Research and Quality [AHRQ] or equivalent), patient safety questionnaires or qualitative approaches.
Supporting and celebrating WHO patient safety days	<ul style="list-style-type: none"> • World Hand Hygiene Day, 5 May • World Patient Safety Day, 17 September
Terms of reference for committees: <ul style="list-style-type: none"> • Mortality and morbidity • Risk and safety • Environmental safety 	<p>Note: titles of committees may differ.</p> <ul style="list-style-type: none"> • List of members • Minutes of meetings • Samples of case reviews and actions taken

Document	Evidence to include
*Risk management programme	<ul style="list-style-type: none"> • Process to identify and mitigate risks, adverse incident reporting system. • A risk register template/spreadsheet designed to systematically track and evaluate risks, define risk priority and potential impact, and document mitigation strategies, and including spaces to document risk descriptions, risk owners, triggers, probability and action plan with timelines. • A list of “never events” and how they are prevented. Never events are serious medical errors or adverse events (e.g. wrong-site surgery or hospital-acquired pressure ulcers) that should never happen to a patient. • How feedback on risk is communicated to all staff and the board. • Training of staff on incident reporting process.
Communications strategy	<ul style="list-style-type: none"> • Key responsible person. • Process for circulation of information: <ul style="list-style-type: none"> o routine o high risk • Policies for: <ul style="list-style-type: none"> o clinical handover: Situation, Background, Assessment, Recommendation (SBAR) o telephone orders, including “read back” whereby the verbal or telephone order is written down completely by the receiver, who then reads back the order, which is confirmed by the person who gave the order o reporting critical results o abbreviation policy
*Patient safety programme	<ul style="list-style-type: none"> • Schedule of clinical and environmental audits • Key performance indicators (KPIs) • Action plans • Reports to staff • Benchmarking results for: <ul style="list-style-type: none"> o international best practice o other, PSFHF
Preventative maintenance programme for equipment	<ul style="list-style-type: none"> • Asset register of all equipment • Schedule of routine tests and calibration • Process to replace faulty equipment • Staff training logs
Human resources (HR) plan	<ul style="list-style-type: none"> • Numbers of staff required to provide services • Policy on validating staff credentials and qualifications • Professional development programme
Occupational health programme	<ul style="list-style-type: none"> • Manual health training • Vaccinations and screening • Violence prevention programme • Staff wellness: <ul style="list-style-type: none"> o rostered breaks o mental health o workplace assessments

Document	Evidence to include
*Policy on control and development of policies	<ul style="list-style-type: none"> • System for consistent template for policy development. • Documentation control system, including review date, publication date, person responsible, signed off by person in authority.
Medical records	<p>Polices on:</p> <ul style="list-style-type: none"> o content of medical record o generating unique patient identifier o validating patient identification o requests from patients for information <p>Audit of:</p> <ul style="list-style-type: none"> o completeness of medical records o legibility of handwriting o chart availability

2. Domain B: Patient and public involvement

Document	Evidence to include
Documented and approved patient and family rights statement in which patient safety is incorporated	<p>Patient rights statement that includes, but is not limited to, the right to:</p> <ul style="list-style-type: none"> o access to care in the hospital o respect patients' cultural and spiritual beliefs and personal preferences o be informed and involved in all medical decisions during their care o compliment/complain o refuse treatment o security, privacy and confidentiality o have pain managed o access to information about hospital services and outcomes
Policy on informed consent	<ul style="list-style-type: none"> • List of procedures for which informed consent is required includes, but is not limited to, invasive procedures, surgical procedures, anaesthesia, blood transfusion, high-risk procedures, high-risk treatments, and organ donation and transplantation. • Informed consent forms that are available in relevant departments. • Informed consent forms that are completed, signed, dated and timed, and available in patients' medical records.
Policy on patient identification	<ul style="list-style-type: none"> • Identification using two identifiers before administration of medication, carrying out any procedure, and verification of identity before any high-risk procedures. • List of high-risk procedures, including blood transfusion and chemotherapy administration. • Patient identification and verification policies and procedures that contain special emphasis on high-risk groups (e.g. newborn infants, patients in a coma, vulnerable patients). • The patient identifiers include full name of patient (to the third generation of the family), date of birth, photograph and hospital number, and are used consistently throughout the hospital.

Document	Evidence to include
Strategy for engagement and empowerment of patients for patient safety	<ul style="list-style-type: none"> • Areas of patient involvement may include patient identification, monitoring hand hygiene and single use of injections. • Existence of any educational material and/or written/verbal information provided to patients that empowers them to play an active role and become partners for promoting patient safety. • Reports or minutes of meetings that include engagement of patients and their carers in setting policies and suggesting quality improvement and patient safety projects.
Process of how to complain	<ul style="list-style-type: none"> • Process to include, and the person responsible to acknowledge and act on complaints. • How patients are communicated with. • Log of complaints and actions over the previous 12 months.
Strategy for engagement of the community in patient safety campaigns	<ul style="list-style-type: none"> • Hand hygiene campaigns • Meetings with civil defence • Media campaigns
Patient services programme	<ul style="list-style-type: none"> • Patient advocate • Health promotion programme • Access to education and information leaflets • Access to the hospital website
Feedback	<ul style="list-style-type: none"> • Measuring patient experiences • Satisfaction surveys • Patient reported outcome measures (PROMs)

3. Domain C: Safe evidence-based clinical practice

Document	Evidence to include
Job description: medical director	Person responsible for clinical guidance, oversight and evaluation of effectiveness of all clinical care.
*Schedule of audits and related action plans	<p>Examples:</p> <ul style="list-style-type: none"> o hand hygiene o IPC o medication safety o emergency response times o door-to-needle times (thrombolytics in the emergency department [ED]) o triage times
Process to identify which clinical policies are required and implementation	<ul style="list-style-type: none"> • Terms of reference for the clinical guideline committee. • Process to sign off and distribute. • Procedures to include, but not limited to: <ul style="list-style-type: none"> o safe surgery o safe childbirth o recognize clinical deterioration
Care bundles	<p>Bundles could include:</p> <ul style="list-style-type: none"> o provision of integrated care o VAP o CLABSI o urinary tract infection (UTI) o sepsis

Document	Evidence to include
Assessment tools to manage and mitigate patients at risk	Tools could include: <ul style="list-style-type: none"> o Deep vein thrombosis and pulmonary embolism o Suicide risk o Morse–Humpty Dumpty Falls Scale
Infection prevention and control (IPC) programme	<ul style="list-style-type: none"> • Person responsible • IPC manual • Surveillance programme • Staff screening • Audit schedule • Isolation • Policies on, but not limited to: <ul style="list-style-type: none"> o hand hygiene o rational use of antibiotics o water, sanitation and hygiene (WASH) o WHO guidelines on IPC o surgical-site infections o safe supply of water
Blood	Procedures on: <ul style="list-style-type: none"> o safe prescribing o cross-match o post-transfusion reaction
Medication safety	<ul style="list-style-type: none"> • Clinical pharmacist job description. • Patient education information. • System for monitoring and mitigating medication errors. • Policies on, but not limited to: <ul style="list-style-type: none"> o procurement, availability and storage of medicines o limited access and standardization of high concentrations/risk substances o polypharmacy and de-prescribing o reconciliation on discharge o use of controlled substances

4. Domain D: Safe environment

Document	Evidence to include
Terms of reference for the health and safety committee or equivalent	<ul style="list-style-type: none"> • Organization structure • Person responsible for environmental issues • Committee members • Sample minutes of meetings and actions taken
Preventative maintenance programme	<ul style="list-style-type: none"> • Schedule of tests and calibrations • Process for managing recalls • Availability of backup equipment

Document	Evidence to include
External emergency plan	A major emergency/disaster plan is a detailed document and should be specific to the hospital and the community where the hospital is located. Both internal and external emergencies require plans that clearly define roles and responsibilities of all staff in the event of an incident. Plans are required to identify the probable impact and what extra services will be required.
Internal emergency	Internal emergencies may arise due to fire, floods or technology break downs. First, an internal plan should cover safe evacuation when required, and then explain how to resume services as quickly as possible. A hospital may find itself in a scenario where part of the facility is substantially damaged, e.g. by a flood or a fire, in this event and internal emergency plan is useful. This is a plan for what to do when either the technology, building or a department are severely impacted, and services are disrupted. The ultimate goal is to resume business functions to a normal state after as short a period as possible following a disaster.
Waste management	<ul style="list-style-type: none"> • Storage, disposal secure area • Sharps • Body fluids • Biological waste • Chemical waste

5. Domain E: Life-long learning

Document	Evidence to include
Staff orientation programme	
Professional Development Programme	<ul style="list-style-type: none"> • Job description for professional development officer • Training and education
Research programme	<ul style="list-style-type: none"> • Research • Publications • Quality improvement programme (QIP)

C. Observation guides

The observation guides in the *Patient safety assessment manual* are focused on the priority patient safety areas common to all hospitals, including:

- general items
- environmental facility and inpatient areas
- fire safety
- laboratory and blood bank
- radiology
- operating room
- central sterilization unit
- pharmacy
- medical records.

Surveyors, who are external peer reviewers of organizational performance against agreed standards, visit each area regarding general safety issues (e.g. fire, waste, signage) and department specific concerns (e.g. radiation safety or security). To avoid duplication, the first guide is a list of general items to be observed or staff to be questioned and are applicable to all departments.

1. General

Observation	Questions
Policies and procedures available in the department.	Who is in charge of this department?
Hand hygiene practices.	What are the qualifications of the staff present?
Continuous professional development.	What patient safety training have staff received in the last 12 months?
Waste segregation and management.	What audits does this department conduct, how often and how is what is learned addressed?
Patient rights statement	
Infection, prevention and control (IPC) practices.	Who operates special equipment?
Equipment maintenance, date machines were last tested and asset number.	How do you know medical devices are safe?
Emergency equipment, including resuscitation trolley and defibrillator.	
Signage.	
Emergency exits.	
Patient waiting rooms, comfort and gender separation if appropriate.	
Patient identification.	
Suggestion boxes.	

2. Environmental facility and inpatient areas

Observation
External signage to emergency department.
Emergency and special needs parking.
Tidy, well maintained and free of rust, dust, dirt, debris, spillages, blood or body substances.
Design addresses best practices for infection control, security, safe egress and exit.
Availability of storage space.
Warning signs for “cleaning in progress”.
Free from offensive odours and well ventilated.
Equipment maintenance.
Restricted access to high security areas, e.g. paediatrics and delivery unit.
Call system for patients.
Emergency communication system for all codes, e.g. cardiac arrest, security, fire.
Emergency generators.
Storage of medical gases.
Storage of hazardous substances.

3. Fire safety

Observation
Fire evacuation plan posted throughout the hospital.
Fire alarms present and in working order.
Clear fire exits and stairways.
Fire hoses in working order.
Flammable liquids stored securely, and their use restricted.
Exit signs clearly marked, lit and all exit doors fire-resistant.
High dependency areas have access to cut off medical gases in an emergency.
All fire extinguishers have current labels dated and signed.
All compressed gas cylinders chained or safely secured.
All cylinders stored in shade and correct temperature away from direct sunlight and heat sources.
Valve protection cap is in place when oxygen cylinder is not in use
Full and empty oxygen cylinders stored separately in an upright position.

4. Laboratories

Observation
Registering all samples received.
Transport of samples.
Equipment maintenance.
First aid equipment, including eye wash and chemical spill kit.
Quality control of results.
Patient identification.
Communication of critical values.
Communication of pending test results after patient discharge.
Storage of blood and products.
Cross-matching process.
Chemical waste management.

5. Radiology

Observation
Registering all patients received.
Patient identification.
Quality control of results.
Handling and storing hazardous material.
Radiation safety programme.
Warning signs marking unsafe areas.
Lead aprons.
Radiation monitoring system.
Warning signs regarding pregnancy.

6. Operating rooms and central sterilization units

Observation
Restricted access.
Segregation of clean and dirty spaces.
Patient informed consent.
Patient identification.

Observation

Critical values.

Safe surgery and anaesthesia practices.

Quality control of sterilization.

Patient handover.

7. Pharmacy

Observation

Quality control of dispensers and laminar flow.

Patient identification.

Availability of life-saving medications.

Process for storage of medications.

Process for ordering and transcribing.

Process for preparing and dispensing.

Process for administration and follow-up.

Concentrated solutions.

Look-alike sound-alike medications.

Medication reconciliation at admission and discharge.

Patient (or carer) education about medication at discharge.

Medication error reporting.

Handling and storing hazardous material.

8. Medical records

Observation

Chart audits.

Patient identification.

Single personal identification number (PIN).

Clinical auditing.

Archiving system.

Standardized coding of diseases.

Observation

Content of medical record:

- completeness
- allergies
- continuity of care: diagnosis, treatment and follow-up
- medication reconciliation.

Accessibility of medical records.

List of approved abbreviations.

Completeness.

Patient identification, unique identifier.

Consent.

Handwriting.

Nurses' notes.

Physicians' notes.

Disease coding.

Presence of a computerized physician order entry.

Presence of an effective automated clinical alarm system.

Easy access for patients and providers.

D. Interviews and onsite agenda

The suggested survey agenda is based on a 500-bed hospital, lasting three days and with two surveyors (see below). The agenda will differ by hospital depending on the services provided and the number of surveyors onsite. There must be at a minimum two surveyors to agree a rating and the final outcome with recommendations. Some hospitals can be surveyed in one day, others may take three days, although the majority probably will last two days. The aim of the onsite survey is for surveyors to seek information to rate a hospital's compliance with the Patient Safety Friendly Hospital Framework (PSFHF). They must continually ask the questions: Are patients safe? How can I as an expert in patient safety assist this organization to mitigate safety issues? And most importantly: Is there a safety issue that warrants direct intervention before I leave?

The interview section suggests key questions for various interviews. As hospitals differ, interviews will also change, especially as job titles can often be different. In smaller hospitals, one person may hold many responsibilities and one or two committees can cover a number of specialties. A report template is also included.

Suggested survey agenda

Day 1			
Time	Activity	Area/department	Hospital staff
8:00–8:15	Patient Safety Friendly Hospital Framework (PSFHF) briefing and agenda review	Meeting room	Hospital leadership (e.g. hospital director, heads of department)
08:15–08:45	Hospital overview presentation (using hospital in brief form) Hospital manager and senior patient safety staff (hospital leadership brief evaluators about hospital capacity and services)	Meeting room	Hospital leadership
08:45–12:00	Document review (all documents should be gathered in a room for surveyors to review)	Meeting room	1 hospital staff member from the patient safety department to be available to the survey team
12:00–12:30	Brief tour of the hospital to familiarize the survey team		1–2 members from the hospital to accompany the survey team
12:30–13:15	Lunch		
13:15–14:00	Surveyors 1 and 2 Interview with hospital leadership focusing on Domain A	Meeting room	Any/all members of the hospital senior management team (senior nurse, senior administrator, medical director) who can answer questions regarding Domain A

Day 1			
Time	Activity	Area/department	Hospital staff
14:00–15:00 Tours of departments combined with interviews	Surveyor 1 Medical ward and patient Medical outpatient department (OPD) and patient X-ray department	Surveyor 2 Labour room and mother Neonatal intensive care unit (NICU) and a relative Day surgery	1 hospital staff member from the patient safety department to be available to the survey team
15:00–15:45	Surveyor 1 Safety tour of hospital focusing on Domain D	Surveyor 2 Interview with patient services officer and community representative focusing on Domain B	
15:45–16:30	Surveyors team meeting identifying issues and any clarifications required	Meeting room	No hospital staff

Day 2			
Time	Activity	Area/department	Hospital staff
8:00–10:30 Tours of departments combined with interviews	Surveyor 1 Emergency department Pharmacy manager interview Laboratory Surgical ward and patient Paediatric ward and relative	Surveyor 2 Burns X-ray Blood bank manager interview Gynaecology ward and patient Waste storage area	1 member from the hospital, patient safety or quality managers with each surveyor
10:30–11:00	Break: surveyors' option to request further documentation		
11:00–12:15 Concurrent interviews, two meeting rooms required	Surveyor 1 Interviews 1. Infection control manager 2. Director of nursing 3. Clinical director	Surveyor 2 Interviews 1. Patient safety and quality officers 2. Occupational health professional 3. Professional development officer	
12:15–13:15	Surveyors 1 and 2 Interview with multidisciplinary (MDT) clinical teams to focus on Domain C	Meeting room	MDT could include doctor, nurse, occupational therapist, physiotherapist, pharmacist, members from infection control, blood bank and laboratory, medical director MDT will depend on services provided by the hospital

Day 2			
Time	Activity	Area/department	Hospital staff
13:15–14:15 Lunch	Surveyors team meeting (identifying missing gaps for assessment and clarifications)	Meeting room	No hospital staff
14:15–16:00 Tours of departments combined with interviews	Surveyors 1 Theatre: central sterile services department (CSSD) Kitchen and dietician human resources manager interview Physio department manager	Surveyors 2 Adult intensive care unit (ICU) and a relative Laundry Medical records and manager Laboratory and manager	1 member from the hospital, patient safety or quality managers with each surveyor
16:00–16:30	Surveyors meeting to identify issues from Day 1	Meeting room	No hospital staff

Day 3			
Time	Activity	Area/department	Hospital staff
8:00–09:00	Surveyors 1 and 2 Interview with environmental safety team focusing on Domain D	Meeting room	Members could include engineer, fire safety officer, infection control, waste manager, patient safety officer, head of maintenance, head of purchasing
10:00–11:00	Surveyors option to request final interviews, tours or documents		1 member from the hospital, patient safety or quality managers with each surveyor
11:00–13:00 Lunch	Surveyor meeting to decide ratings of all critical criteria and decide recommendations to discuss with senior management	Meeting room	No hospital staff
13:00–13:30	Discuss findings and recommendations with senior hospital management	Meeting room	Hospital leadership (e.g. hospital director, steering committee members, survey coordinators)
13:30–14:00	Discuss findings and recommendations with hospital staff		
14:00–17:00	Surveyors to agree all ratings by the end of the survey Report completed within two weeks of survey		

Key questions for interviews

Interview with senior patient safety leader

1. Does the hospital have patient safety as a strategic priority? Is this strategy being implemented through a detailed action plan?
2. Does the hospital have a designated senior staff member with responsibility, accountability and authority for patient safety?
3. Does the hospital have an annual budget for patient safety activities based on a detailed action plan?
4. Does the leadership conduct regular patient safety executive walks to promote patient safety culture, learn about risks in the system and act on patient safety improvement opportunities?
5. Does the hospital follow a code of ethics, for example, in relation to research, resuscitation, consent, confidentiality and relations with industry?
6. Does the leadership regularly assess staff attitudes towards patient safety culture?
7. Are qualified clinical staff, both permanent and temporary, registered to practise with an appropriate body?
8. Do students and trainees work within their competencies and under appropriate supervision?
9. Does the hospital have policies and procedures for all departments and services?

Interview with hospital management

1. Is patient safety a strategic priority?
2. Is there a detailed patient safety action plan?
3. Is there a designated senior staff member with responsibility, accountability and authority for patient safety?
4. Does the hospital have an annual budget for patient safety activities based on a detailed action plan?
5. Does the hospital conduct regular patient safety executive walks?
6. If yes, how frequently?
7. Does the hospital follow a code of ethics, for example, in relation to research, resuscitation, consent and confidentiality?
8. Does the hospital regularly assess staff attitudes towards patient safety culture?

Interview with patient safety officer

1. Does the hospital have a programme of patient safety and risk management in operation?
2. If so, what does it include?
3. Infection control?
4. Safe use of medicine?
5. Safe environment of care?
6. Safe clinical practice?
7. Equipment safety?
8. Emergency management?
9. Are patient safety programme activities coordinated with the quality improvement department?
10. How do you integrate different patient safety activities?

11. What are the focuses of the programme?
12. What is your role as a patient safety and risk management coordinator?
13. Are patient safety incidents reported and analysed?
14. Does the patient safety reporting ensure confidentiality?
15. Does patient safety reporting minimize individual blame?
16. Does patient safety reporting allow for ease of reporting?
17. Does the hospital have an active patient safety internal body that analyses prioritized events?
18. Who are the stakeholders involved in the patient safety internal body?
19. Which tools does the patient safety internal body use to analyse and recommend patient safety improvement activities?
20. Currently, are there any patient safety improvement projects?
21. If so, what are the details of the projects?
22. Is there a standard procedure for patient safety?
23. Does the hospital have a morbidity and mortality committee?
24. How often do the morbidity and mortality committee members meet?
25. Does the hospital develop reports on different patient safety activities, and does it disseminate them?
26. Does the hospital have measurable targets related to patient safety goals?
27. Does the hospital have a set of output indicators that assesses performance with a special focus on patient safety in the form of patient safety report cards?
28. Does the hospital have a set of process indicators that assesses performance with a special focus on patient safety in the form of patient safety report cards?
29. Does the hospital send the patient safety report cards on a monthly basis to the national organization responsible for oversight of patient safety friendly hospitals (e.g. Ministry of Health) for benchmarking with other hospitals?
30. Does the hospital act on benchmarking results through an action plan and development of patient safety improvement projects?
31. Does the hospital have campaigns on patient safety?
32. How does the hospital involve its community in patient safety activities?
33. Does the hospital have a structured disclosure system?
34. Does the hospital have a health care mediator to disclose incidents?
35. Does the hospital obtain patients' and their carers' feedback?
36. If so, using which tools?
37. Satisfaction surveys?
38. If so, how often?
39. Leadership walk-arounds?
40. If so, how often?
41. Focus groups?
42. If so, how often?

43. Complaint letters?
44. Safety hotline?
45. Staff feedback?
46. Suggestion box?
47. Community surveys?
48. Does the hospital involve patients and their carers in setting policies and implementing quality improvement and patient safety activities?
49. If so, how?
50. Does the hospital provide chat/message board for patients and their carers to write their concerns and share their solutions?
51. Does the hospital provide access to computer-based information on patient safety, health literacy and patient well-being?
52. Does the hospital conduct cross-sectional studies to assess magnitude and nature of adverse events?
53. If so, how frequently?
54. Does the patient safety internal body approve and monitor patient safety research?
55. Does the hospital conduct retrospective record review studies to assess the magnitude and nature of adverse events?
56. If so, how frequently?
57. Does the patient safety task force use scientific tools, e.g. root cause analysis and improvement tools, e.g. Plan Do Study Act?
58. Does the hospital publish internal research reports that include statistics on frequency of iatrogenic harm, and does it communicate results for action both internally and externally?
59. Does the hospital use large data sets and prospective studies to assess the magnitude and nature of adverse events?

Interview with infection prevention and control (IPC) officer

1. Does the hospital have an infection prevention and control policy?
2. Does the hospital have an infection prevention and control committee?
3. Does the hospital have an infection prevention and control organizational chart?
4. Does the hospital have a surveillance system for health care-acquired infections?
5. Does the hospital assess infection control?
6. If so, how?
7. Does the hospital conform to recognized guidelines for infection prevention and control?
8. Does the hospital implement policies and procedures for rational use of antibiotics to reduce resistance?
9. Does the hospital ensure proper decontamination of all equipment, with a special emphasis on high-risk areas?
10. Does the hospital have an infection control action plan and an assigned budget for it?
11. Does the hospital have an infection control information, education and communication strategy for staff?
12. Does the hospital implement recognized guidelines for hand hygiene, including WHO guidelines?

Interview with patients

1. Were you briefed about the patient and family rights policy of the hospital?
2. Is the patient and family rights statement visible throughout the hospital?
3. Did you obtain complete updated information on your diagnosis, treatment or prognosis from your treating physician?
4. Did you participate in making decisions regarding your health care?
5. Did you give signed consent before any risky procedure?
6. Did the hospital train you or your carers to take care of you after you were discharged?
7. Did you receive patient education concerning your case/diagnosis upon discharge?
8. Did you receive information about your medication?
9. Are hospital staff respondent to your needs and caring?
10. Did the hospital have patient entertainment?
11. In general, did hospital staff treat you with care and respect?
12. In general, were the hospital staff friendly to you?

Interview with blood bank manager

1. How does the hospital implement safe blood and blood product guidelines?
2. How does the hospital ensure that patient blood samples for cross-matching are securely identified with two unique identifiers?
3. Does the hospital have safe pre-transfusion procedures, e.g. recruitment, selection and retention of voluntary blood donors, blood screening (e.g. HIV, hepatitis B virus/HBV)?
4. Does the hospital have a policy for management of post-blood exposure incidents?

Interview with medical records officer

1. Is there a unique identifier and record for every patient?
2. Does the hospital have policies and standard operating procedures regarding medical records?
3. Does the hospital use standardized codes for diseases?
4. Does the hospital have automated information management and electronic medical records?
5. Does the hospital have an effective automated clinical alarm system?

Interview with occupational health and environmental safety officer

1. Does the hospital have a multidisciplinary environmental safety committee?
2. Does the hospital have a preventive and corrective building safety programme?
3. Does the hospital have a security programme?
4. Does the hospital have an external disaster action plan?
5. If so, how frequently is it rehearsed?

6. Does the hospital have an internal disaster action plan?
7. If so, how frequently is it rehearsed?
8. Does the hospital have a fire safety programme with special emphasis on high-risk areas, such as laboratories and kitchens?
9. Does the hospital have emergency lighting and power in high-risk areas (e.g. operating room, intensive care unit [ICU], blood bank and medical gas system) and elevators?
10. Does the hospital have an effective utility system plan, comprising a preventive maintenance and backup plan in case of failure or interruption?
11. Does the hospital have a radiation safety programme?
12. How does the hospital ensure appropriate and safe food and drink for patients, staff and visitors?
13. Does the hospital implement a smoke-free policy?

Interview with clinical director/medical staff

1. Does the leadership support staff involved in patient safety incidents as long as there is no intentional harm or negligence?
2. What communication process do doctors use to transfer patient information between colleagues?
3. Does the hospital follow a code of ethics, for example, in relationship to research, resuscitation, consent and confidentiality?
4. In your opinion, is there an open, non-punitive, non-blaming, learning and continuously improving patient safety culture at all levels of the hospital?
5. Does the leadership assess staff attitudes towards patient safety culture regularly?
6. Does the hospital ensure that staff receive appropriate training for available equipment?
7. Are all patients identified and verified with at least two identifiers, including full name and date of birth?
8. Does the hospital conform to clinical practice guidelines where appropriate, including WHO guidelines where available? Can you provide examples of such guidelines from your area of expertise?
9. Is there a system in place to ensure that invasive diagnostic procedures are carried out safely, and according to standard guidelines?
10. Does the hospital implement guidelines to reduce venous thromboembolism?
11. In your practice, do you commonly screen patients to identify those vulnerable to harm (e.g. falls, pressure ulcers, suicide, malnutrition or infection)?
12. Does the hospital maintain a list of approved abbreviations of medical terms?
13. Does the hospital minimize the use of verbal and telephone orders and transmission of results, and is “read back” used where verbal communication is essential?
14. Does the hospital maintain clear channels of communication for urgent critical results?
15. Does the hospital have systems in place to ensure safe communication of pending test results to patients and care providers after discharge?
16. Does the hospital have systems in place for safe and thorough handover of patients between clinical teams?
17. Does the hospital have a local guideline committee that meets regularly to select, develop and implement guidelines, protocols and checklists relevant to safety?

Interview with the director of nursing

1. Does the leadership support staff involved in patient safety incidents as long as there is no intentional harm or negligence?
2. What communication process do nurses use at handover between shifts?
3. In your opinion, is there an open, non-punitive, non-blaming, learning and continuously improving patient safety culture at all levels of the hospital?
4. Does the leadership assess staff attitudes towards patient safety culture regularly?
5. Does the hospital undertake regular preventive maintenance for equipment, including calibration?
6. Does the hospital undertake regular repair or replacement of broken (malfunctioning) equipment?
7. Does the hospital ensure that staff receive appropriate training for available equipment?
8. Does the hospital ensure that all reusable medical devices are properly decontaminated prior to use?
9. Does the hospital have sufficient supplies to ensure prompt decontamination and sterilization?
10. Are all patients identified and verified with at least two identifiers, including full name and date of birth?
11. Is there a system in place to identify allergies, e.g. by a colour-coding system?
12. Do you take into consideration the feelings of patients and their carers during all processes of care?
13. Are you given instructions by hospital leadership to support patients' families and carers in end-of-life cases?
14. Are there systems in place to ensure safe injection practice through:
 15. Preventing reuse of needles at hospital?
 16. Educating patients and families regarding transmission of bloodborne pathogens?
 17. Ensuring safe syringe disposal practices, e.g. no recapping, and use of safety boxes?
 18. Ensuring skin preparation (aseptic) before administration of any injections, infusions and immunization?
 19. Guidelines for anaphylactic reactions that might occur following injections, infusions and immunization?
20. Were you provided with a patient safety orientation programme?
21. Is there ongoing training for all staff to ensure safe patient care?
22. Are you familiar with the reporting procedure and steps to be taken during and after an adverse event?
23. Do you have any broken equipment?
24. Did you ever face any delays in patient treatment due to malfunctioning equipment?
25. What happens if equipment breaks/malfunctions?
26. Were you trained in relevant equipment use, decontamination and sterilization?
27. Do you brief patients about the patient and family rights policy of the hospital?

Interview with the professional development officer

1. Does the hospital have a patient safety orientation programme?
2. Does the hospital have a staff professional development programme with patient safety as a major theme?
3. If so, what does it include?
4. Are all staff familiar with the reporting procedure and steps to be taken during and after an adverse event?
5. Does the medical staff committee monitor competency (qualifications) for all health care professionals working in the hospital?
6. Does the hospital verify competency for all health professionals working through an internal medical credentialing committee?
7. If yes, is there evidence to support this?

Interview with clinical director/medical staff

1. How many staff are in charge of health care waste management?
2. Did they receive any kind of training?
3. Are the staff aware of risks of handling health care waste?
4. Does the hospital vaccinate its staff against hepatitis B and other infectious diseases?
5. Does the hospital segregate its waste?
6. Does the hospital use any colour coding for the waste system?
7. What protective equipment do staff use in handling waste?
8. Do you have special containers for infectious waste?
9. Do you have special containers for sharps?
10. Is the storage area for waste secured?
11. Is health care waste collected and transported in a safe way?
12. How is health care waste treated?
13. Does the hospital conform to guidelines on management of biological waste?
14. Does the hospital conform to guidelines on management of sharps?
15. Does the hospital conform to guidelines on management of chemical waste?
16. Does the hospital conform to guidelines on management of radiological waste?
17. Where is the final health care waste disposal site?
18. How many cases were reported for needle stick injury in the past six months?
19. What measures does the hospital undertake when a needle stick injury is reported?

Report template

1.0 Executive summary

Objective

To perform an external assessment of HOSPITAL NAME, against WHO/Eastern Mediterranean Region Patient Safety Friendly Hospital Framework (PSFHF) Standards, third edition.

Settings

HOSPITAL NAME is a PUBLIC/PRIVATE hospital situated in TOWN, COUNTRY. It provides tertiary health care services and has a bed capacity of (number of beds). The hospital provides a wide range of surgical and medical services at inpatient and outpatient settings.

Methodology

The PSFHF comprises of 134 criteria that are prioritized into critical, core and developmental criteria. The 134 patient safety criteria are organized into five domains:

- A. Leadership and management
- B. Patient and public involvement.
- C. Safe evidence-based clinical practice.
- D. Safe environment
- E. Life-long learning.

The PSFHF assessment is a voluntary process and the hospitals are advised to commence with a self-assessment. This identifies the gaps and prioritizes areas to be addressed. The next stage is for a team of external experts to visit the hospital and assess compliance to the 134 criteria. This assessment involves multiple approaches that are triangulated to obtain the results. Documents are reviewed, interviews are conducted and site visits are made to key departments.

Due to the size of HOSPITAL NAME, a team of (3 to 4) PSFHF surveyors conducted the assessment over (3 to 4) days on DATE.

Findings

HOSPITAL NAME achieved (percentage) compliance to the critical standards. They were assessed against 94 core criteria as (number not applicable) were deemed not applicable by the survey team. They achieved a (percentage score) compliance rate to the 94 core criteria. HOSPITAL NAME was assessed against 15 developmental standards and achieved a compliance rate of (percentage score).

Among the five domains, DOMAIN NAME scored first, with a total score of (percentage score). DOMAIN NAME domain scored second with (percentage score), followed by DOMAIN NAME at (percentage score). The DOMAIN NAME domain scored fourth with (percentage score) and the DOMAIN NAME scored fifth with (percentage score). The overall compliance rate for critical, core and developmental in the five domains was (percentage score).

Conclusions

As the hospital meets (percentage score) of the critical standards, (percentage score) of the core standards and (percentage score) of developmental standards, HOSPITAL NAME, is assigned (level) compliance with the PSFHF standards.

2.0 Introduction to PSFHF

3.0 Introduction to HOSPITAL NAME

4.0 Assessment methodology for HOSPITAL NAME

Based on the WHO/Eastern Mediterranean Region, *Patient safety assessment manual*, third edition, the following assessment methodology was applied in HOSPITAL NAME.

An external evaluation survey team was on site for two days DATE

- NAME, COUNTRY
- NAME, COUNTRY
- NAME, COUNTRY

The assessment involved review of documents, interviews with key stakeholders and observational visits to key departments, see Appendix 1 (HOSPITAL NAME Agenda). The staff of HOSPITAL NAME are to be commended for their hospitality, openness and can-do attitude witnessed during the assessment. Documents were clearly indexed and easy to find.

5.0 Findings

5.1 Domain A: Leadership and management standards

5.1.1 Strengths

5.1.2 Opportunities for improvement

5.2 Domain B: Patient and public involvement standards

5.2.1 Strengths

5.2.2 Opportunities for improvement

5.3 Domain C: Safe evidence-based clinical practice standards

5.3.1 Strengths

5.3.2 Opportunities for improvement

5.4 Domain D: Safe environment standards

5.4.1 Strengths

5.4.2 Opportunities for improvement

5.5 Domain E: Life-long learning standards

5.5.1 Strengths

5.5.2 Opportunities for improvement

6.0 Conclusions

7.0 Recommendations

7.1 Short term

7.2 Long term

Patient safety standards are critical for the establishment and assessment of patient safety programmes within hospitals. This third edition of the *Patient safety assessment manual* provides an updated set of standards and assessment criteria that reflect current best practice and WHO guidance. The manual will support the implementation of patient safety assessments and improvement programmes within hospitals as part of the Patient Safety Friendly Hospital Framework to ensure that patient safety is prioritized and facilities and staff implement best practices. The manual is a key tool for use by professional associations, regulatory, accrediting or oversight bodies, and ministries of health to improve patient safety.

