

SE 2: Operational Programme Governance, Management and Leadership (District Health Management Teams and Programme Coordinators)

Overview

The programme-specific *operational* standards define the performance expectations, structures and functions that must be in place at national and health district level for a clinical programme to be compliant with the standards.

Standards at this level of service are generic and apply to any clinical care specific programme and include standards for district level programme management as well as standards for coordination of support services such as laboratory, radiology, Central Sterile Supplies (CSS), supply chain management, maintenance, transport, IT support and hotel services (food services, housekeeping, laundry) across all facilities (public and private) at national and health district levels.

The programme standards apply only to the programme-specific systems that are essential for effective programme service delivery and are supplementary to the detailed service standards that are part of the existing Hospital and Clinic facility standards.

Coordinating patient care among various providers and across multiple care settings from a hospital to a clinic, health post and the patient's home is a huge challenge. Various contributing system factors can have a negative effect on care coordination including patient transport, information that is unavailable, inaccurate, not timely, or incomplete, as well as patients' limitations in understanding their health needs (for example understanding the medication they are taking and why, knowing whom to see for a particular care issue) so that they or a designee can safely and reliably care for themselves.

As healthcare is increasingly delivered outside of hospitals, district health management teams and Programme Coordinators must work with providers at all levels of care (in public and private health facilities) to identify the care coordination challenges that arise beyond the hospital in ambulatory settings and in post-acute care. Identifying these issues and finding solutions to these complex patient safety issues requires vertical programmes for patient care to be integrated across the continuum of care and for the support of smooth and effective care delivery and transitions between the various levels of care.

District Programme Coordinators should be appointed in all districts to coordinate and manage the specific programmes and to liaise with the governance structures of all of the district's public and private hospitals and clinics as well as the designated programme Focal Persons within facilities and patient advocate groups in the community.

The term **"Programme Leaders"** is used in the standards to refer to the combined group of senior leaders involved in programme delivery, including the National Programme Coordinator(s), District Health Management Teams, District Programme Coordinators, Facility and Service Managers and programme Focal Persons.

Standards

2.1 Operational programme management and support

2.1.1 *The clinical programme leaders are identified and are collectively responsible for defining the programme's mission and creating the operational plans needed to fulfil the mission.*

Overview and Standard Intent

A programme's mission statement usually reflects the needs of its catchment population. All healthcare facilities derive their mission from the needs of their catchment population but programme-specific services must be planned and designed to respond to those needs within a larger geographical area, the whole country and/or the specific health district.

While managers are appointed to posts and have a leadership role, leaders for a programme may arise from many sources. These leaders may represent every level and service in healthcare, for example medical, nursing, maintenance, administration, physiotherapy and radiography. Leaders may also be

nominated or elected to certain committees, for example health and safety committees and infection control committees. Effective leadership is essential for a programme to be able to operate efficiently and fulfil its mission. Leaders may have formal titles or may be recognised for their seniority, stature or contribution to the programme. It is important that all the leaders of a programme are acknowledged and brought into the process of defining the programme's mission.

Patient care services should be planned and designed to respond to the needs of the patient population. Leaders of the various facilities, clinical departments and services in a given healthcare district will determine which diagnostic, therapeutic, rehabilitative and other services are essential to the catchment population as well as the scope and intensity of the programme services to be provided. In private healthcare facilities those persons who have an interest or a share in the services should be consulted during the planning processes.

2.1.1 Criteria

2.1.1.1 The leaders of the programme at national and district level are formally identified.

Guideline Statement:

This information can be obtained from various sources such as the organogram, job descriptions, performance agreements, letters of appointment to committees, designation of leadership roles for various tasks/responsibilities, etc.

2.1.1.2 The leaders of the programme identify the desired or expected programme related services for a specific catchment population within the health district.

Guideline Statement:

The services provided should match the needs of the catchment population. In public healthcare districts and facilities, the needs of the population are usually identified by government and the information passed on to the district health management team (DHMT) and healthcare facilities. In private healthcare facilities the senior management team and the governing body should undertake activities to establish the needs of the catchment population, for example by consulting with referring healthcare organisations and providers as well as the District Health Management Team head and Programme Coordinator. Evidence to support compliance could be in the form of a list of services provided by each facility, facilities referral structure, minutes of meetings and operational plans.

2.1.1.3 The programme leaders work collaboratively to develop and implement the strategic plan and operational goals of the national healthcare programme.

Guideline Statement:

The term "strategic plan" does not necessarily mean a single document as indicated below. Sometimes organisations refer to "business/operational" plans which may be separate entities or be integrated into the "strategic plan".

In assessing compliance in the public sector, the designated "level" of the programme (basic or comprehensive) within the district's various facilities (district hospital, primary hospital, private hospital, clinics) and its "service package" as published in national and programme-specific documents should be considered.

2.1.1.4 Progress in implementing the programme delivery plan is monitored at regular intervals according to national strategic goals and M&E framework.

Guideline Statement:

Time-bound, measurable targets or deadlines should be identified in relation to meeting the goals of the strategic plan. This should be achieved through a programme-specific M&E framework. Senior management meetings should review the achievement of these targets at pre-defined intervals according to national programme policy, for example quarterly or monthly, and take action when they are not met.

2.1.1.5 The programme leaders meet at regular intervals to determine resources required to meet the needs of the catchment population.

Guideline Statement:

Resource needs include all staffing, training, equipment, medication, transport, clinical and non-clinical support services required at all levels of care. Documented evidence of such meetings, for example minutes of the meetings, should be made available for assessment. The strategic and operational plans of the healthcare facility should reflect the decisions taken during these meetings.

2.1.2 *Operational programme activities in the district are supported by relevant policies and procedures.*

Overview and Standard Intent

At district management level, District Health Management Team heads, Programme Coordinators, Facility Managers and Heads of Departments and services are responsible for ensuring effective management and leadership of personnel responsible for specific programme service delivery. Policies and procedures are formulated at different levels of authority, for example national acts and regulations, national health and labour departmental policies, programme-specific policies and hospital policies.

Managers have to ensure the availability, distribution and implementation of national programme-specific and other policies and procedures directly or indirectly required for delivering a safe, quality service within the district, as well as policies that address district specific protocols and procedures.

In general, the policies or procedures specifically required for district operations should address:

- Quality assurance considerations for relevant support services (laboratory, radiology, CSS, equipment maintenance, supply chain management including medication)
- Transport services for patients
- Operational transport (for example transport of laboratory specimens from clinic to district/referral hospital laboratory)
- Hotel service delivery in clinics with beds
- Communication and coordination amongst public and private sector facilities and home-based care
- Occupational Health and Safety (for example radiation safety, post exposure prophylaxis etc.)

Policies relevant to any clinical programme within the district should address: **

- Special consent considerations
- Programme-specific monitoring and evaluation requirements
- Special qualifications or skills of personnel involved in the care process
- Safe use of drugs in programme-specific patient care
- Availability and use of resuscitation equipment and medication
- How planning for programme operations will occur
- The documentation required, for example professional clinical guidelines and legislation, order forms, communication forms, etc. for the care team to work effectively
- Programme-specific admission, transfer, discharge requirements
- Programme-specific referrals
- Infection prevention and control
- Risk management

**Information with regard to detail required for certain policies relevant to individual programmes is included in SE 3.

Efficient management and implementation of the programme's policy and procedure framework will be greatly facilitated by the inclusion of the following minimum requirements for each policy and procedure/standard operating procedure/pathway/etc.:

- Title: Each policy should have a name or title for identification and reference
- Identifying number: This is to facilitate indexing, locating the policy when required and communicating about the policy accurately
- Policy statement: What is to be achieved and why
- Procedure: How the policy is to be achieved. This is a step-by-step description of what needs to be done (like a recipe, following each step should result in a predictable outcome irrespective of who follows the steps)

- Associated references: This is required when the policy is directly associated with specific laws, regulations or policies or corporate policies and procedures
- Dates: The date of the original policy, the date(s) of any revision(s) and the date of the next planned review
- Signature: This is the signature of the person identified and authorised by the governing body of the hospital to approve policies and procedures

Programme leaders must ensure that all policies and procedures, including those that apply to a specific programme, are available to personnel in all the facilities within the district, that they are implemented as they relate to various departments, services and functions and that the implementation is monitored. Facility Managers should ensure that policies and procedures are available to guide personnel in matters such as allocation, use and care of resources, financial practices, human resource management, complaints management and delegations of authority within the healthcare facility.

2.1.2 Criteria

2.1.2.1 The district's programme leaders ensure that policies and procedures guide and support the operational activities and management of the programme.

Root Criterion:

Guideline Statement:

This is a "root" criterion and should be scored compliant only if there are no critical/very serious non- or partially compliant criteria, or not many other non- or partially compliant "policy and procedure" criteria in any of the other service elements.

2.1.2.2 Policies and procedures guide the development, retention and destruction of all programme documentation including patient-related information, legal, managerial and research documentation.

Guideline Statement:

These policies and procedures should be developed collaboratively by all stakeholders and should meet legal requirements where relevant.

2.1.2.3 The District Programme Coordinator is responsible for compiling and indexing programme-specific policies and procedures and ensuring their circulation, recall, archiving and review.

Guideline Statement:

Evidence will be obtained from the documented designation/delegation of such responsibility to an individual. This criterion is not prescriptive in terms of whether the individual operates independently or acts as a coordinator of a team or chairperson of a committee. The criterion should not be scored compliant if there is evidence of non- /partial execution of the listed tasks.

2.1.2.4 Programme-specific policies and procedures are signed by persons authorised to do so.

Guideline Statement:

This is measured against the documented arrangements regarding such authorisation. Some policies are developed and authorised at national level, others (mainly operational policies and protocols) at district or facility level.

2.1.2.5 Programme-specific policies and procedures are compiled into a comprehensive manual(s) or filing system (paper-based and/or electronic) which is indexed and easily accessible to all personnel involved in rendering programme-specific services, both in the public and the private sector.

Guideline Statement:

This should be interpreted to mean more than one manual – paper-based or electronic.

*The effectiveness of the indexing system needs to be tested by random checks on cross-references between manuals and policy documents.
Accessibility should be tested at district level, especially in the case of electronic systems.*

2.1.2.6 All policies and procedures are reviewed at appropriate intervals, dated and signed.

Guideline Statement:

*The general approach is not to penalise the criterion where there are only a few documents that do not comply. In other words, the general trend should be taken into consideration.
It is expected that policies will be reviewed whenever indicated by evidence based changes in current practice, but time frames for the routine review of policies should be defined in district health management policy. It is generally accepted that a period of two to three years between reviews should not be exceeded.*

2.1.2.7 There is a mechanism to ensure that policies are known and implemented.

Guideline Statement:

Compliance can be demonstrated in various ways as healthcare facilities have different ways of performing these tasks.

Examples of making policies known may include:

- Personnel indicate their acknowledgement by signing on the reverse of each document, on the index or on a separate sheet/form, thus undertaking to keep up to date with all relevant policies*
- Key policies and procedures are discussed at meetings*
- Memos are circulated to inform personnel of new/changed policy matters, etc.*

The criterion is not prescriptive regarding the method to be used but the system in operation should be tested for effectiveness. Personnel do not necessarily have to receive formal in-service training on policies, but this often happens for important/key aspects.

2.1.3 The programme is supported by an effective district wide laboratory service system.

Overview and Standard Intent

Laboratory services form an essential component of IMCI and ETAT care and form an integral part of good programme planning and delivery.

Reliable, integrated and well managed district and private laboratory services for basic and specialised laboratory investigations are essential for improving quality, efficiency and cost-effectiveness of the programme and to reduce morbidity and mortality.

District and private laboratory services must be consistent, dependable and accessible to all facilities and provide a service that meets the expectations of Facility Managers and Programme Coordinators, healthcare workers as well as the community.

Laboratory services, including those required for emergencies, may be provided within a facility, by agreement with another hospital or both, if outside sources are convenient for the patient to access. Whatever the arrangement, it is expected that laboratory services will be available continuously on site or in close proximity to the healthcare facility that offers an IMCI and ETAT care programme.

The district's laboratory services must have the ability to perform a range of investigations and other basic tests to assist in the diagnosis, assessment, treatment and prevention of common diseases. Where laboratory facilities are not available on the premises, clinic-based 'diagnostic point-of-care' screening, for example for anaemia, proteinuria, blood glucose and rapid antibody screening are performed within the clinic by non-laboratory personnel who give rapid results. Documented training and quality control are required for all point-of-care tests.

Programme leaders must confer with the district laboratory to establish a reliable specimen collection and transport system and to determine the programme-specific essential laboratory tests to be available at the different levels of health facilities as well as additional, essential complex laboratory tests that should be available at a referral laboratory.

All facilities that are served by a specific referral laboratory must be provided with a manual for handling of specimens, procedures for collection, necessary containers for collection and training for non-laboratory staff that provide these services on site.

The laboratory service participates in external laboratory quality assurance programmes, regular reports of which should be made available to the district health team head and programme leaders.

2.1.3 Criteria

2.1.3.1 An IMCI programme appropriate diagnostic laboratory service is offered at all levels of health service delivery in the district.

Guideline Statement:

The programme-specific tests to be available at different levels of facilities within the district have to be determined by the programme leaders together with the relevant laboratory provider. Minutes of meetings and a current approved list/policy must be available.

2.1.3.2 A current manual/guidelines and steps on how to use various IMCI programme-specific tests, read different test results and assure quality of services are available, distributed and implemented at all healthcare facilities.

Guideline Statement:

Compliance will be determined through evidence of existence and implementation of appropriate guidelines and posters. Interviews with healthcare professionals in different facilities will confirm compliance.

2.1.3.3 A schedule for district wide laboratory specimen collection and delivery is implemented.

Guideline Statement:

The schedule has to be available for all healthcare facilities and includes porter schedules/protocols for facilities with an in-house laboratory and transport schedules for clinics and health posts.

2.1.3.4 Appropriate laboratory turn-around times for individual facilities have been established and monitored.

Guideline Statement:

Turn-around times are dependent on many factors including distance from the laboratory, specimen collection schedules and transport and communication systems and may vary from facility to facility. Patient safety has to be considered when targets are set. Clear distinction is made between turn-around times from sending by the facility to receiving the result and turn-around times within the laboratory. This will identify specific areas for improvement in the process.

2.1.3.5 The district programme leaders have access to regular laboratory quality reports.

Guideline Statement:

Criterion compliance requires evidence of availability of reports and sharing of relevant information with programme leaders.

2.1.4 The programme is supported by an effectively coordinated district wide diagnostic imaging service system.

Overview and Standard Intent

Diagnostic imaging is one of the most important diagnostic services in the frontline of medical care. Ultrasound and x-ray are ideal diagnostic tools because they can meet 70-80% of all clinical diagnostic needs. Their absence increases the risk of misdiagnoses, treatment delays and negative healthcare outcomes.

Safe, reliable, integrated and well managed district imaging services are essential for improving quality, efficiency and cost-effectiveness of the programme and to reduce morbidity and mortality.

Public and private imaging services must be consistent, dependable and accessible to all facilities and provide a service that meets the expectations of Facility Managers and Programme Coordinators, healthcare workers as well as the community.

Basic diagnostic imaging services should be available at all 'first referral level' facilities (clinics with beds, district hospitals) to which patients from primary healthcare facilities (health posts, clinics) can be referred and where diagnosis, treatment and care is available 24 hours per day.

A coordinated district referral system for timely access to specialised diagnostic imaging services (CT, MRI) should be in place.

The potential to reduce child mortality and morbidity is addressed in the national goals.

In order to provide reliable imaging services in remote clinics and hospitals within a health district, issues such as electrical power, patient transport, trained operators (radiologists, radiographers and ultrasonologists) and the possibility to train non-specialist clinical staff (generalist doctors) to operate equipment (for example ultrasound) must be addressed (Detail included in SE 3).

Use of portable ultrasound should be considered for improved access in remote rural settings in order to improve appropriate case management of clinical problems encountered at district healthcare level. Indications for the use of imaging technology must be clearly specified within specific levels of care and a mechanism of ensuring adherence to these criteria must be established.

Communication with patients and appropriate information about the benefits and limitations of ultrasound are essential to alleviate fear, and to discourage irrational expectations and demand.

2.1.4 Criteria

2.1.4.1 An IMCI programme appropriate diagnostic imaging service is accessible at all levels of health service delivery in the district.

Guideline Statement:

The programme-specific diagnostic imaging services to be available at different levels of facilities within the district have to be determined by the programme leaders together with the relevant service provider. Minutes of meetings and a current approved list/policy must be available.

2.1.4.2 A current manual/guidelines and steps on when and to use various IMCI programme-specific diagnostic aids, interpret images and assure quality of services are available, distributed and implemented at all healthcare facilities.

Guideline Statement:

Compliance will be determined through evidence of appropriate guidelines, posters and interviews with healthcare professionals in different facilities.

2.1.4.3 A training plan for the use of portable ultrasound equipment by non-specialist healthcare workers is available and implemented.

Guideline Statement:

Training is a major factor in the success of a medical imaging service as the level of the diagnoses is dependent on the ability of the radiographer. A locally provided training programme supported by specialists is vital to the establishment of a useful and sustainable service.

2.1.4.4 A referral schedule for a district wide diagnostic imaging system is implemented.

Guideline Statement:

The schedule has to be available for all healthcare facilities and includes fixed days and dates for booking routine diagnostic imaging procedures at designated referral facilities (for example TB screening) and should include coordinated transport schedules for patients from clinics and health posts.

2.1.4.5 Appropriate turn-around times for individual facilities have been established and are monitored.

Guideline Statement:

Turn-around times are dependent on many factors including distance from the referral facility, patient transport schedules and transport and communication systems and may vary from facility to facility. Patient safety has to be considered when targets are set. Clear distinction is made between turn-around times from booking or sending the patient from the primary facility to receiving the result and turn-around times within the diagnostic service provider. This will identify specific areas for improvement in the process.

2.1.4.6 The district programme leaders have access to regular diagnostic imaging service provider quality reports.

Guideline Statement:

Criterion compliance requires evidence of availability of reports and sharing of relevant information with programme leaders.

2.1.5 The programme is supported by an effectively coordinated district wide Central Sterile Supplies (CSS) Service.

Overview and Standard Intent

Sterile medical instruments and supplies can prevent some of the most common infections acquired through wounds, surgical incisions and during childbirth and also during minor procedures such as ear-wicking, airway manipulation and insertion of IV lines and nasogastric tubes.

All healthcare facilities should have access to sterilization equipment to reduce disease transmission. While the World Health Organisation (WHO) recommends using autoclaves (technologically advanced sterilizing equipment) at the district hospital level, there are various innovations for sterilization that could be useful in low-resource settings.

Access to an effective, district wide, coordinated sterilisation service has to be in place to ensure the consistent availability in all district facilities of sterile instruments and packs required for rendering a safe and effective service. Several sets of duplicate surgical instrument packs may be needed to cover all common surgical and obstetric procedures and to allow continuous provision of services during sterilisation.

The provision of sterilisation services is centralised in many health districts through a district or referral hospital or private contractor with the advantage that appropriately high standards of processing can be more consistently achieved and monitored. This system however requires fixed schedules for sending and receiving items, coordinated reliable transport services and could cause critical delays and shortages should the service be unavailable due to technical failures or high workloads.

Alternatives like table top autoclaves for larger clinics could be considered. This requires a reliable power supply.

All facilities should have a designated area for cleaning, rinsing and drying instruments before sending them to a CSS department or autoclaving on site. Training must be provided for designated personnel in a clinical setting.

2.1.5 Criteria

- 2.1.5.1 Designated CSS service providers are available for all levels of health service delivery in the district.**

Guideline Statement:

The specific facilities/contractors providing sterilisation services at different levels of facilities within the district have to be determined by the programme leaders. Minutes of meetings and a current approved list/policy must be available.

- 2.1.5.2 Supervision and technical support is available for facilities that use on-site sterilising equipment.**

Guideline Statement:

Compliance will be determined through evidence of regular maintenance reports and staff interviews.

- 2.1.5.3 A manual for the use of on-site sterilisation equipment by healthcare workers is available and implemented.**

Guideline Statement:

Compliance will be determined through evidence of appropriate guidelines, posters and interviews with healthcare professionals in different facilities.

- 2.1.5.4 A fixed day/date schedule for delivering and receiving sterile packs and instruments from/to the CSS service provider is implemented.**

Guideline Statement:

The schedule has to be available for all healthcare facilities and includes fixed days and dates for sending and receiving items and should include coordinated transport schedules from and to clinics and health posts.

- 2.1.5.5 Appropriate turn-around times for packs from and to individual CSS service providers have been established and are monitored.**

Guideline Statement:

Turn-around times are dependent on many factors including distance from referral facility and transport and communication systems and may vary from facility to facility. Patient safety has to be considered when targets are set. Clear distinction is made between turn-around times sending the packs/items from the primary facility to receiving them back and turn-around times within the CSS service provider. This will identify specific areas for improvement in the process.

- 2.1.5.6 Sterile Surgical instruments/packs needed to cover all common paediatric procedures are available at all times.**

Guideline Statement:

This requires daily auditing, collection, collating, submitting and analysis of data as well as documented evidence of action plans.

- 2.1.5.7 The district programme leaders have access to regular CSS service provider quality reports.**

Guideline Statement:

Criterion compliance requires evidence of availability of reports and sharing of relevant information with programme leaders. This should include traceability of all sterile instruments and sterile packs as well as expiry dates for use.

- 2.1.6 The programme is supported by an effectively coordinated district wide transport system.**

Overview and Standard Intent

After personnel and medicine, transport is one of the highest cost drivers for health services and it is therefore important that transport is provided in the most efficient, cost-effective way to ensure quality of healthcare. This standard applies only to the regular district transport systems that are essential for programme service delivery; emergency vehicle (ambulance) services are excluded. Criteria that address vehicle maintenance, licensing of drivers and vehicles, legal requirements for driving motor vehicles and transporting passengers and other administrative logistics are assessed as part of the existing Hospital and Clinic facility standards.

Vehicles are required for transport and transfer/referral of patients from the community to health facilities and between levels of healthcare; delivery of essential equipment, medicine, laboratory specimens and other supplies to point of service delivery; transport of Programme Coordinators for supervisory visits, to attend meetings and training sessions and for other administrative purposes.

Transport systems are not merely a support activity to be provided by others, but an essential service for enabling effective implementation of health programme policies. Many of the management and planning problems involving transport derive from the vertical organisation of health services and therefore require multi-disciplinary planning and coordination between all role-players, services and departments at National and District level.

Availability of appropriate vehicles for programme service delivery must be ensured when required. If adequate and timely transport is not available, services can be seriously affected and compromised and expected service delivery goals will not be met.

An effective and efficient system does not only require the correct number and vehicle mix, suitable for the topographical area in which the service is provided, but also availability of drivers.

WHO studies and other surveys have identified lack of timely patient transport as one of the major contributing factors to child morbidity and mortality. It is imperative that all facilities that render IMCI services should have 24/7 access to functional vehicles that can be used for emergency patient transportation and a designated driver in near proximity to the facility and adequate fuel. For clinics that render routine primary healthcare services, emergency transport should be available within a reasonable time as determined by National ER guidelines. Rural clinics located further than a distance determined by the district management teams from a district hospital may require on-site vehicles and drivers.

The use of vehicles needs to be controlled because of the cost of acquiring and maintaining vehicles and the legal requirements for driving motor vehicles and transporting passengers.

Appropriate quality management systems must be implemented to ensure that the service monitors its performance and addresses any improvements required in order to provide an effective and efficient service to support patient care within the district.

2.1.6 Criteria

2.1.6.1 A coordinated, district wide, plan is in place for the allocation, control and use of vehicles required for the programme.

Guideline Statement:

This evidence should be available in the district management team's head office. Minutes of multidisciplinary meetings between district programme leaders and transport providers should be available. Documented evidence is required.

2.1.6.2 The ability of the transport service to meet the transport needs of the programme's personnel and patients is monitored on a regular (at least quarterly) basis.

Guideline Statement:

This requires an evaluation of the utilisation of vehicles for programme-specific purposes over a specified period of time and reporting of any problems affecting service delivery and/or patient safety. Documented evidence is required.

2.1.6.3 There is a system for booking transport in advance.

Guideline Statement:

Programme-specific needs must be considered, for example 'TB x-ray' or 'ultrasound days' for patients at referral hospitals and Programme Coordinator schedules for regular facility support visits. Assessment of compliance with this requirement should focus on the existence of documented evidence of such arrangements. Documented evidence is required.

2.1.6.4 All clinics have access to a vehicle and driver for urgent patient transfer during operational hours.

Guideline Statement:

Transport should be available within a reasonable time. On-call services should be available at health posts and clinics for emergencies outside of operational hours 24/7. There should be recorded/documentated evidence that the availability is randomly checked and recorded. Appropriate response time has to be determined and monitored. Documented evidence is required.

2.1.6.5 Quality management processes are designed and implemented.

Guideline Statement:

Any district level activities to improve management of transport within the programme, for example improving response times to requests for bookings and patient referrals etc. will satisfy the requirement of this criterion. This includes identification and reporting of risks and incidents as well as actions taken. Documented evidence is required.

2.1.7 The programme is supported by an effectively coordinated national and district wide supply chain management system.

Overview and Standard Intent

An effective supply chain system for medicine, surgical materials, other consumables and clinical diagnostic equipment (for example glucometers, diagnostic sets) requires a timely, reliable movement of health supplies as well as data up and down the supply chain from the service delivery point such as health posts, clinics and hospitals to district and national/central levels and back. In order to make informed decisions on the types and levels of supplies required, reliable data and timely information is crucial. The implementation of modern information technology is the most efficient and cost-effective approach to collect information about service delivery, point of care consumption and to monitor the flow of supplies along the distribution channels within a district.

Supply chain managers must ensure that facilities are provided with the supplies that are needed in time. They are responsible for ensuring suppliers and their products maintain safety and quality standards such as, for example, verification that the cold chain was maintained for vaccines and other drugs. This information must be accessible to the District Health Management Team, Programme Coordinators and Facility Managers on request.

Managing inventory at facilities does not only involve counting how much stock is available in a store or dispensary but also keeping enough inventory on hand to ensure flexible service delivery that meets all provider, customer and client expectations.

A centralised district level system (instrument bank) which allows for urgent, temporary or permanent replacement of clinical diagnostic equipment such as glucometers, haemoglobin photometers and diagnostic sets which are sent for repairs or calibration should be available.

Patients and customers must be able to receive the drugs and medication that they need close to the places where they live at appropriate regular intervals. This requires a careful balance between carrying enough stock but not so much stock that budgets are affected. Orders have to be submitted in time to ensure all items (or components of an item) arrive at the designated facility without major delays.

Programme Coordinators must be able to determine how many patients in need of treatment received the treatment, follow the progress of the intervention, continuously assess the risks facing the programme and evaluate internal inventory control issues reported by facilities.

2.1.7 Criteria

2.1.7.1 A centralised district level plan for the allocation, distribution and control of drugs, medication and consumables required for the programme is in place.

Guideline Statement:

This evidence should be available in the District Health Management Team head and/or Programme Coordinator's office. Minutes of multidisciplinary meetings between district programme leaders and supply chain managers should be available. Documented evidence is required.

2.1.7.2 A coordinated district wide system for urgent, temporary replacement of diagnostic equipment required for the programme is in place.

Guideline Statement:

This evidence should be available in the District Health Management Team head and/or Programme Coordinator's office. Minutes of multidisciplinary meetings between district programme leaders and supply chain managers should be available. Documented evidence is required.

2.1.7.3 The ability of the central supply stores to meet the drugs, medication, consumables and equipment needs of the programme is monitored on a regular (at least quarterly) basis.

Guideline Statement:

This requires an evaluation of the stock levels of drugs, medication, consumables and equipment for programme-specific purposes over a specified period of time and reporting of any problems affecting service delivery and/or patient safety. Documented evidence is required.

2.1.7.4 There is a system for calculating and predicting district-wide programme-specific stock turnover and requirements.

Guideline Statement:

Programme-specific needs must be considered, for example, annual peak birth months, historical data on seasonal child disease patterns and unexpected disease outbreaks. Assessment of compliance with this requirement should focus on the existence of documented evidence of such arrangements. Documented evidence is required.

2.1.7.5 All facilities have access to an electronic as well as a paper-based back up supply chain management system.

Guideline Statement:

There should be recorded/documentated evidence that the availability is randomly checked and recorded. Appropriate response time has to be determined and monitored. Documented evidence is required.

2.1.7.6 Quality management processes are designed and implemented.

Guideline Statement:

Any district level activities to monitor and improve supply chain management within the programme, for example improving response times to ordering and receiving stock, cold chain management from central stores to service areas etc. will satisfy the requirement of this criterion. This includes identification and reporting of risks and incidents as well as actions taken. Documented evidence is required.

2.1.8 Administrative support services are available to support district programme

activities.

Overview and Standard Intent

Programme leaders must have access to an effective and efficient administrative support system for the planning, organisation and coordination of programme related managerial processes including financial management, information management and health record management. Support services such as health record management and financial management may be located in individual facilities, for example district hospitals. Programme leaders must be included in the development and management of budgets relevant to specific programme needs.

A dedicated information management team for clinical programme support should be in place at district level. Data and information is a resource that must be collected and used at all levels for planning and monitoring against data quality and health programme targets. Programme quality and improvement cannot be achieved without adequate, effective data collection, aggregation, analysis and reporting systems to help the programme leaders understand its current performance and identify opportunities for improvement.

Data capturers are responsible for capturing data and then forwarding the data to the next level. These responsibilities are similar for all health programmes and all levels at which data is captured.

2.1.8 Criteria

2.1.8.1 There is a mechanism for programme leaders to participate in the development and management of programme related budgets.

Guideline Statement:

Documented evidence is required of the participation of Programme Coordinators in the budgetary and financial management processes at facility and district level. This can vary widely between different organisations, from minutes of meetings to structured “cost-centre based” financial statements.

This criterion will be scored PC where there is no evidence that Programme Coordinators were provided the opportunity to participate in financial management decisions, for example financial planning for programme-specific personnel, equipment, consumables and medication and how funds should be allocated and spent.

2.1.8.2 Processes are in place to aggregate data required by Programme Coordinators.

Guideline Statement:

Programme-specific data collected and aggregated by the district’s facilities has to be collated at district level. Documented evidence of a protocol that describes the process and implementation thereof must be provided.

2.1.8.3 A designated data and information management team supports implementation of the programme’s information management system.

Guideline Statement:

Evidence of a designated team at district health management level is required.

2.1.8.4 Required technology and other resources support the implementation.

Guideline Statement:

Resource requirements may differ vastly between paper-based and computerised systems and the assessment of compliance needs to take these factors into account. In many instances such technological support may be provided from a corporate level.

2.1.9 Programme leaders participate in developing and monitoring contracts/agreements relevant for clinical and non-clinical programme support

services across all facilities.

Overview and Standard Intent

Within a health district, clinical, non-clinical and managerial services are either provided directly by the facility or such services are arranged through referral, consultation, contractual arrangements or other agreements. Such services may include, for example radiology services, laboratory services, CSS services, transport services, equipment management, hotel services, etc.

In all cases, Health District Management Teams, Programme Coordinators and Facility Managers must supervise such written contracts/agreements to ensure that the services meet patient needs and are monitored as part of the district's and programme's quality management and improvement activities.

Please note, the reference to "clinical" in the above intent as the "outsourcing" of clinical services is an integral part of this section and applies especially to private providers such as emergency response services and radiology services. District-level contractual arrangements with private doctors and other healthcare professionals (session holders who work scheduled/fixed-day programme related sessions in various clinics and hospitals within a district) in the public sector should also be considered in this section. Contracts with healthcare professionals who only render services in one specific facility are excluded and are monitored by the Facility Manager.

Arrangements with agencies for the provision of professional personnel such as locum doctors and nurses are included here.

2.1.9 Criteria

2.1.9.1 Copies of contracts are made available to those who ensure their implementation.

Guideline Statement:

At district level, copies of the contracts entered into by public facilities within the district must be made available to the programme leaders. It is not necessary for all details of the contract, for example financial details, to be made available to these individuals. However, the details regarding services to be delivered must be made available so that they can ensure the terms of service are met and are able to take action when they are not met.

In private facilities, this responsibility rests with the Facility Manager.

2.1.9.2 Services provided under contracts/agreements meet programme-specific patient needs.

Guideline Statement:

Programme leaders must ensure that programme-specific needs are communicated and included in the relevant contract, for example provision of food for patients who stay overnight in so-called 'clinics with beds'.

Commonly, this will apply to contracted services for catering, laundry/linen, housekeeping, security, maintenance of buildings, plant and equipment, provisioning services, for example medication, coal for boilers, etc. It can also apply to providing personnel such as agency nurses, locums, artisans, technicians, etc.

If contracts/agreements exist, this criterion is scored compliant by default unless non-conformance by other service elements indicate a definite shortfall that can justify a NC/PC rating. Where services are rendered without a formal contract/agreement this will be scored PC.

2.1.9.3 Contracts and other arrangements are monitored as part of the programmes' quality management and improvement programme.

Guideline Statement:

The reference to 'quality management and improvement programme' indicates formal monitoring of analysed data.

Assessment of this requirement should take into consideration that compliance can be achieved in various ways, for example through formal monitoring tools/checklists, satisfaction surveys, minutes of meetings, renegotiations of contractual arrangements/specifications, service level agreements with service performance indicators, etc.

This criterion cannot be scored compliant if copies of the contracts are not available at district management level.

2.1.9.4 There is a mechanism to ensure that all volunteers work under the guidance of suitably qualified personnel in the employ of the facility.

Guideline Statement:

Volunteers are not formal employees of the facility and should therefore not be allowed to work unsupervised in order to safeguard patient safety. An example would be family members preparing food for patients in a rural clinic.

2.2 Professional programme management, supervision and support

2.2.1 Policies, procedures, protocols, forms and guidelines required for support of clinical activities are available and implemented.

Overview and Standard Intent

Policies, procedures, protocols, forms and guidelines for programme-specific clinical care have to be based on evidence-based national or international guidelines as well as current systematic review of existing academic literature to facilitate the delivery of safe and effective clinical care, treatment and services across all facilities.

These documents are unique to a specific programme and apply to a designated group of healthcare professionals who render the service within a given facility or unit across the entire continuum of care. Some policies are relevant for all facilities while others only apply to hospitals and referral level facilities.

An indexed folder (electronic or paper based) of all policies, protocols, guidelines, forms and manuals must be available at national and district programme level as well as at facilities and clinics where services are rendered.

Minimum requirements for each policy, procedure, protocol, form and guideline as detailed in the intent statement for 1.1.2 apply.

2.2.1 Criteria

2.2.1.1 The programme leaders ensure that programme-specific clinical policies, procedures and forms are compiled and indexed and ensure their circulation, recall, archiving and review.

Guideline Statement:

The availability of a clinical policy manual/folder at the district management team office, national programme office and facility will be confirmed.

2.2.1.2 Programme-specific policies, procedures, protocols and/or forms are available to support its practices across the entire programme care continuum.

Guideline Statement:

This criterion requires evidence that the documents are available, up to date and have been distributed to the facilities.

Implementation will be assessed at individual facility level

*For **Emergency Triage and Treatment (ETAT)** this includes at a minimum policies and/or protocols for the following:*

- A complete training manual for all workers in the service area*
- Standardized ETAT color-coded tool for publication in all units*
- Triage protocol for all paediatric patients (new-born to 5 years old) including time limits for each category*
- Assessment of priority signs*

- *Protocols for assessment and management of ABCD principles (Airway, Breathing, Circulation/Coma/Convulsion, Dehydration)*
- *Protocol for use of the AVPU scale*
- *Medication administration protocols for all medication by age/weight groups*
- *Treatment protocols for all identified priority cases including procedures for insertion of oropharyngeal airway, oxygen treatment, insertion of IV-line with appropriate fluids, checking of blood glucose levels, insertion of nasogastric tube, vascular access sites, etc.*
- *Reassessment of patients, and follow-up treatment*
- *Blood transfusion*
- *Standardized assessment and treatment forms*

For Integrated Management of Childhood Illness (IMCI) - Sick Infant Age birth up to 2 Months this includes at a minimum the following:

- *Regular and special consent procedures*
- *Policies and procedures for registration, identification and medical records completion for the patient*
- *Full assessment of the child, including history and physical examination*
- *Assessment of child development*
- *Psychosocial risk assessment, screening, and referral for care (including, assessment of the mother or caretaker)*
- *Classification of the sick infant according to specific signs*
- *Control of infections or other communicable conditions*
- *Medication administration protocols for all medication by age/weight groups*
- *Protocols for treatment of various classifications (jaundice, dehydration, HIV, feeding)*
- *Assessment and follow-up on the child's Immunization, vitamin A status*
- *Protocols for follow-up care for acute conditions*
- *Protocols for counselling the mother or caretaker*
- *Breastfeeding - initiation, support, and when to stop*
- *Infant and young child feeding*
- *Planning for discharge and follow-up care*
- *Stabilizing and transferring patients who require care beyond the scope of services provided by the organization*
- *Resuscitation of a new-born*
- *Standardized assessment and treatment forms*

For Integrated Management of Childhood Illness (IMCI) - Sick Child Age 2 Months up to 5 Years this includes at a minimum the following:

- *Regular and special consent procedures*
- *Policies and procedures for registration, identification and medical records completion for the patient*
- *Full assessment of the child, including history and physical examination*
- *Assessment of child development*
- *Psychosocial risk assessment, screening, and referral for care (including, assessment of the mother or caretaker)*
- *Classification of the sick child*
- *Danger signs*
- *Control of infections or other communicable conditions*
- *Medication administration protocols for all medications by age/weight groups*
- *Protocols for treatment of various classifications*
- *Protocols for follow-up care for acute conditions*
- *Protocols for counselling the mother or caretaker*
- *Breastfeeding - initiation, support, and when to stop*
- *Treatment protocols for all classifications, including procedures for insertion of oropharyngeal airway, oxygen treatment, insertion of IV-line with appropriate fluids, checking of blood glucose levels, insertion of nasogastric tube, vascular access sites, ear-wicking, preparation of ORT and other meals/fluids, etc.*
- *Assessment and follow-up on the child's Immunization, vitamin A and deworming status*

- *Guidelines for assessment, testing, treatment and follow-up of HIV and HIV exposed*
- *Guidelines for assessment of fever, classification, testing and treatment for related diseases*
- *Guidelines for assessment and treatment of ear, nose, throat and eye infections*
- *Paediatric resuscitation*
- *Planning for discharge and follow-up care*
- *Stabilizing and transferring patients who require care beyond the scope of services provided by the organization*
- *Standardized assessment and treatment forms*

2.2.1.3 The programme leaders ensure implementation of amendments to clinical protocols, procedures, guidelines and forms in response to changes in evidence-based national or international guidelines, systematic review of existing evidence or results of analysed data and clinical audits.

Guideline statement:

Evidence will be in the form of minutes of meetings, documented correspondence and evidence of availability and implementation of updated policies, procedures, protocols, guideline documents and forms.

2.2.2 A programme-specific training plan for the district is in place and is implemented.

Overview and Standard Intent

The Ministry of Health has developed several training manuals including a comprehensive training manual on Integrated Management of Childhood Illness IMCI which is used for in-service training of health workers working in paediatric settings to improve clinical performance.

The development of national and/or district training plans for the provision of programme-specific training and skills development and 'train the trainer' initiatives should be included in the annual goals of National Programme Coordinators and District Programme Coordinators.

Adequate training will ensure that health workers have the skills and knowledge to provide appropriate care at the most vulnerable period of the infant and young child's life. Training manuals provide guidelines for improving the quality of Emergency Triage and Treatment and classifications and treatment of the sick infant up to age 2 months and the sick child age 2 months to 5 years. When implemented, this will ensure that care is timely and efficiently provided and that knowledge/skill gaps of practitioners are identified and proper remedial action is taken.

Selecting, orienting, educating and training healthcare professionals on programme-specific care procedures is the combined responsibility of facility, unit, service as well as Programme Coordinators and Focal Persons. Training should cover both in-service training as well as regular basic training, skills updates and mentorship programmes to ensure that all healthcare professionals who render programme-specific services are adequately trained and competent. Frequency of compulsory competency testing, refresher courses and skills-update workshops should be determined by programme leaders. Outcomes of competency testing have to be documented, tracked and analysed over time and indicators included in the programme's M&E framework.

Competent healthcare practitioners (nurses, doctors and other healthcare workers) will be able to think critically in emergency situations and make effective decisions on the basis of solid knowledge and understanding of paediatric practices.

Where volunteers such as community health workers, health promotion workers and family members are involved to support the programme, the necessary orientation and education has to be provided to ensure safe and effective service delivery, coordinated with other services within the facility.

2.2.2 Criteria

2.2.2.1 District programme leaders ensure that a district wide, coordinated orientation plan

for the programme's healthcare professionals is implemented.

Guideline Statement:

A district orientation plan must be available including data on evidence of completion of orientation of facility staff must be provided to the District Programme Coordinator. Where volunteers are used to support the programme, relevant orientation has to be provided and documented. Content and detail of the orientation is detailed in SE 3.

2.2.2.2 The programme has a coordinated plan for in-service training and development which is implemented.

Guideline Statement:

Evidence of training session attendance must be provided. Analysed attendance data should be available, for example what percentage of which category of personnel attended which training session.

2.2.2.3 There is a district wide post-basic training strategy for the programme which ensures that all personnel regularly update their knowledge and skills.

Guideline Statement:

The strategy should be designed to ensure that all personnel are included and their training activities tracked to ensure that they attend the planned training. The strategy should also ensure that the changing requirements of the programme over time are met.

2.2.2.4 Data on training outcomes and competencies are monitored and analysed.

Guideline Statement:

Documented evidence of collection, collation and analysis of data over time is required.

2.2.2.5 Opportunities for quality improvement are identified and action plans implemented.

Guideline Statement:

Documented evidence of specific quality improvement projects is required.

2.2.3 A formal plan for supervision and monitoring of the programme in all the district facilities is available and implemented.

Overview and Standard Intent

Programme leaders have to provide overall management of programme-specific services rendered in the district.

While effective referral, provision of essential equipment, supplies, medication and recruitment of qualified staff are important to ensure quality programme outcomes, international surveys and studies have confirmed that poor performance within health programmes has been more closely linked to lack of good quality leadership than to a lack of resources and suggest that more attention should be paid to the issues around staff motivation, supervision, support and recognition.

Healthcare facilities should receive at least one supervisory visit that includes observation of case management every three months.

Regular support visits to facilities to support and confirm the compliance with programme-specific guidelines, periodic programme assessments and follow up on training have to be scheduled and conducted. Objective monitoring and supervision with constructive feedback should be a built in tool for the specific programme-related activities carried out at facilities.

Appropriate professional interdisciplinary 'programme supervision teams' that include professional individuals with expertise in and/or knowledge about the programme's specialised care, treatment and

services (for example Nurse Practitioners, Midwives, Doctors, Focal Persons, Programme Coordinators and other local private and public sector personnel should be formed. Such teams should conduct field visits, provide external and supportive supervision including mentoring and supervision of clinical practices, identify technical and operational strengths and weaknesses and share initiatives and experience.

2.2.3 Criteria

2.2.3.1 A district-wide supervisory visit schedule is available and implemented.

Guideline Statement:

Evidence of a documented schedule that includes at minimum four visits per year to all facilities that render programme-specific services in the district is required.

2.2.3.2 Compliance with programme-specific guidelines and protocols are audited.

Guideline Statement:

Documented evidence of audit tools and collated data must be provided.

2.2.3.3 Regular support visits by 'programme supervision support team members' based on individual facility needs are conducted.

Guideline Statement:

Frequency of visits should be determined by identified risks and/or requests by Facility Managers. Names of team members and summary reports of visit findings must be provided.

2.2.3.4 There is a system in place to address staff concerns.

Guideline Statement:

This could be in the form of programme-specific staff surveys, meetings with Focal Persons etc. Documented evidence is required.

2.2.4 A formal, programme-specific, information management and quality plan for the district is available and implemented.

Overview and Standard Intent

Programme leaders are responsible and accountable for the quality of service delivery and health programme data. These responsibilities include the management of high quality information that must be used to optimise patient care and programme-related community services, health outcomes, performance of health programmes within the healthcare system, improving data quality and monitoring, evaluating and reporting on performance against all programme-specific plans and goals in the health sector.

Information generated during patient care should be used for the safe and effective management of the programme. The ability to collect and provide information requires effective planning. Planning should incorporate contributions from a variety of sources, including:

- The care providers
- The Programme Coordinators and programme Focal Persons of facilities
- Those outside the facilities who require data or information about the programme's operational and care processes

The most urgent information needs of these sources will determine the programme's information management strategies and its ability to implement those strategies. The strategies must be appropriate for the diversity of services, availability of trained personnel and other human and technical resources.

Monitoring often focuses on those services and outcomes that are high risk, high volume or problem prone at facility and service level.

The information and quality management plan must be comprehensive and include all facilities, services and care providers in the district.

Data collation and analysis has to consider the requirements of the national programme-specific M&E framework. A data reporting system from districts to the National Programme Coordinator has to be in place and the District Programme Coordinator should monitor the performance of the programme's interdisciplinary facility teams in relation to the programme's mission, goals, and objectives.

Consistent data sets, definitions, codes, classifications and terminology must be used to enable benchmarking against international targets. Data must be relevant to the programme, include specific structure, process and patient outcome indicators and must be timely, accurate and complete.

Patient and staff satisfaction data that is specific to the care, treatment and services provided should be included.

Although computerisation and other technologies improve efficiency, the principles of good information management apply to all methods, whether paper-based or electronic.

Quality improvement activities should be guided by the overall programme framework implemented across the district. The framework should include the full spectrum of clinical and managerial activities and focus on the reduction of risk associated with variation in these activities. Continuous improvement and the maintenance of improvements already achieved require continuous monitoring, analysis and interpretation of key indicator data followed by appropriate interventions when problems are identified. The programme should take into account that most clinical care involves more than one profession. In order for quality improvement activities to be effective, quality improvement interventions should be developed and implemented collaboratively and coordinated between all stakeholders involved in the programme. An interdisciplinary performance improvement committee should be formed and meet a minimum of twice a year to evaluate clinical care practices and protocols.

A standardised framework for the quality improvement (QI) system, based on a cyclic approach such as the WHO PDSA, should be provided by national and programme leaders and used for all QI projects to ensure that these processes are implemented in a planned and coordinated manner. The framework should include protocols for clinical audit and quality improvement cycles.

When performed well, these activities provide the framework for the programme and its leaders to create a culture of continuous quality improvement by providing quality patient care in a safe, well-managed environment.

2.2.4 Criteria

2.2.4.1 Information systems for the programme are developed and implemented.

Guideline Statement:

An executive summary, which reflects all data management components required by the programme, should be available. This should include finances, human resources, equipment, patient care, medication, supplies, quality management, infection control etc.

In many instances such data is collected as part of corporately driven information management systems and may require certain additions/adaptations to such systems in order to extract specific data and reports required for programme monitoring.

2.2.4.2 The programme leaders, in collaboration with subject matter experts, identify key indicators and other information required to monitor quality assurance and improvement processes.

Guideline Statement:

Indicators reflect the scope of service delivery in relation to managerial, clinical and support services (including formal educational services where applicable). Evidence of a current M&E framework has to be available.

2.2.4.3 Programme leaders identify key measures to monitor the quality of clinical

processes.

Guideline Statement:

Evidence of a current M&E framework has to be available.

2.2.4.4 Confidentiality of data and information is maintained.

Guideline Statement:

These aspects need to be documented as part of the information management processes for the various types of information, whether it be financial data, personal information on personnel, patient information etc. Where applicable, country-specific legal requirements need to be considered. Documented evidence is required.

2.2.4.5 Aggregated data and information is used to support management of the programme.

Guideline Statement:

Assessment of compliance is based on the availability of reports on the various types of data as well as documented evidence (for example minutes of meetings or other form of communication) of discussions on the information and how this is taken into consideration to assist with decision-making processes. This needs to happen at all levels of the programme and not just at district management as information also needs to be available on departmental operations such as personnel matters, financial aspects, supply management, outcomes of quality improvement programmes, results from clinical and patient record audits, negative incidents etc.

2.2.4.6 Aggregated data and information is used to identify opportunities for quality improvement.

Guideline Statement:

Documentation demonstrating interventions taken to improve performance on programme core measures, actions to confirm that interventions resulted in improvements and that improvements are maintained must be available.

2.2.4.7 Data or information is contributed to national programme databases as required by law or regulation, where applicable.

Guideline Statement:

Availability of regular reports submitted as required by the national programme directorate.

2.2.4.8 Clinical audits are performed to evaluate the quality of care provided, drive improvements in service provision and monitor performance over time.

Guideline Statement:

Documented evidence of programme-specific, structured clinical audits must be available.

2.2.4.9 Professional performance is monitored as part of clinical monitoring.

Guideline Statement:

A documented process to monitor programme-specific clinical competencies for different categories of staff must be available. Evidence of implementation, for example reports from supervisors and skills assessment outcomes must be provided.

2.2.4.10 Deficiencies in the quality of record keeping are addressed by appropriate interventions.

Guideline Statement:

Programme-specific documentation audits (for example immunisation schedule completion) must be available.

2.2.4.11 Comparisons are made over time within the programme, among districts, and with

national M&E goals and targets.

Guideline Statement:

Analysed data reports must be available.

2.2.4.12 The data collected for monitoring and evaluation purposes is used to inform the development of processes to ensure that improvements are sustained over time.

Guideline Statement:

Minutes of meetings and evidence of implemented action plans must be available.

2.2.5 A formal programme-specific risk management plan for the district is available and implemented.

Overview and Standard Intent

The ultimate goal of a designated clinical programme is to ensure that specific health targets are achieved within a safe, functional and supportive environment for service users as well as providers (patients, families, visitors, personnel and volunteers). To implement an effective risk management strategy, the programme leaders must recognise the interdependencies of risks, for example that the relative safety of the service user and staff is dependent on the safety of the environment in which care is delivered.

Management of clinical, occupational and facility specific environmental risks is the responsibility of individual Facility Managers. At district level, the programme leaders have to consider categories of risk related to operational programme management, including risk to:

- The service user and provider experience
- The compliance with standards by the service provider
- National and district goals, objectives and projects
- Operational and service continuity
- Reputation
- Budget
- The environment

Incident reporting should be part of any facility's risk management processes, however IMCI programme-specific incident categories for reporting should be determined at national programme level.

Programme leaders have to make use of aggregated data and information from all facilities to identify, evaluate, reduce and control hazards and risks to the programme and to identify key clinical risks to the achievement of the programme's strategic objectives.

A well-established process for identifying, reviewing and reporting adverse events, sentinel events and morbidity and mortality cases that occur within the programme has to be in place.

Such events should be investigated by a multidisciplinary expert team at district level and full reports provided to programme leaders at district and national level.

To create consistency, risk assessment tools such as designated forms for adverse event reporting as well as clinical audit and root cause analysis tools have to be provided to all facilities.

Risk reduction strategies based on analysis of aggregated operational data, sentinel events, clinical audits and M&E data have to be implemented and monitored.

2.2.5 Criteria

2.2.5.1 Risk management strategies for the programme are developed and implemented.

Root criterion:

Guideline Statement:

A formal process should be followed to identify and analyse risks to the programme and this will be used to develop the action plan.

The risk management process should include all relevant operations and services within the programme including patient, staff and visitor related risks and financial, corporate and legal risks. This does not necessarily require a single integrated document, provided all components are dealt with in documented systems for the relevant operational processes/functions/sections.

Documented evidence is required.

2.2.5.2 A risk register, including programme-specific reportable operational and clinical risk categories, is developed and implemented.

Guideline Statement:

A risk register is a paper or electronic document which records all identified programme risks along with a ranking of the risk and a summary of the measures taken or to be taken to eliminate or contain the risk. This should be considered a living document which should be updated whenever circumstances or the environment changes or new risks become apparent.

2.2.5.3 There is evidence of ongoing documented monitoring of risks.

Guideline Statement:

This will include both routine inspections to monitor identified risks and responses to risks which have materialised as adverse events.

2.2.5.4 Risk management systems are reviewed and the risk register updated whenever there are changes in processes and policies.

Guideline Statement:

These changes will include redesign of established processes, addition of clinical services, for example the acquisition of a machine for diagnostic imaging, changes in transport schedules, clinical skills development etc.

2.2.5.5 Risk management tools are developed and implemented.

Guideline Statement:

Evidence of programme-specific tools such as adverse event reportable categories, clinical audit tools, and root cause analysis tools must be provided.

2.2.5.6 Analysed data (including adverse events, sentinel events and near misses, morbidity and mortality data, clinical audits, contract compliance, patient survey data) is used to monitor the effectiveness of the risk management system.

Guideline Statement:

This requires the collection and aggregation of data relating to such incidents as well as the analysis of this data. Analysis should demonstrate further interrogation of the data to provide an understanding of why the events occurred, identify any underlying common cause resulting in multiple events and identify patterns and trends within the data. Patterns and trends should be responded to appropriately. Analysis to monitor the effectiveness of the system will require a demonstrated reduction in incidents and/or improvement in set targets which is maintained over time. This can be in relation to all incidents or in relation to patterns of incidents identified within the data, for example delay in transport, unavailable laboratory reports, increase in stillbirths, measles outbreak, etc. Documented evidence is required.