Republic of Botswana

National Health Quality Standards

Standards and Criteria

CONFIDENTIAL

Ministry of Health
Private Bag 0038, Gaborone
Plot 54609, Government Enclave, Gaborone
Tel: 363 2500
Toll free 0800600740

MINISTRY of HEALTH
REPUBLIC OF BOTSWANA

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1.Strategic Programme Governance, Management and Leadership

Overview of Strategic Programme Governance, Management and Leadership

Providing excellent patient care requires effective management and leadership at all levels in a country's healthcare service. Those who provide governance, management and/or leadership have authority and are collectively and individually responsible for meeting the responsibility of the patient population served.

The standards of SE1 are focused on the programme-specific strategic functions of the Ministry of Health and Wellness through National Programme Coordinators and the required communication with the District Health Management Teams (DHMT), referral and private hospital boards and CEOs.

At the governance level, the Ministry of Health and Wellness (MOH&W) is ultimately responsible for strategic planning and is accountable for providing quality healthcare services to their catchment population. The Ministry of Health and Wellness (MOH&W), through the Health Inspectorate division, promotes and drives programmes aimed at improving the quality and safety of healthcare in Botswana through inspections and regulatory mechanisms to ensure conformity by healthcare facilities, institutions and personnel.

Extensive international research has demonstrated that the problem of insufficient implementation of health interventions could generally be attributed to three main interlinking factors i.e. leadership and management, resources and end-user related factors. The leadership and management related factors identified included insufficient commitment of politicians and other key actors which led to insufficient funding of health systems; underutilisation of available resources; lack of enabling policies for healthcare; poor management; misplacement of priorities and lack of credibility, loyalty to the assignments, innovativeness and leadership skills.

Ministerial responsibilities through a team of identified individuals (National and District Programme Coordinators) relevant to a specific health programme (for example Integrated Management of Childhood Illnesses (IMCI), TB prevention and cure, Emergency Obstetric and Neonatal Care (EmONC) and Mental Health Services) include:

- Providing strategic direction for health delivery services
- Formulating and providing programme-specific health policy, standards and direction for all stakeholders in a health programme
- Mobilisation and allocation of resources to all providers in a health programme's delivery services
- Providing relevant and adequate information for coordination and management of health services within a programme
- Providing a regulatory framework for all providers of health services within a programme
- Coordination of activities of the agencies, providers and partners in the health sector
- Monitoring and evaluation of the programme-specific health service delivery by the public health facilities, teaching hospitals, other agencies, development partners and the private sector
- Providing a framework for the development and management of the human resources required for implementing health programmes

- Providing a framework for the effective and efficient procurement, distribution, management, maintenance and use of health sector supplies, works and services

Standards

1.1. Governance of the programme (MOH&W Level)

1.1.1. Governance responsibilities and accountabilities are described in legislation, policies and procedures or similar documents that show how these duties are to be carried out.

1.1.1 Criteria

1.1.1.1. The health programme governance structure (MOH&W level) is described in written documents and is known to the personnel of the district health management teams and healthcare facilities.

Guideline statement:

This governance structure refers to the authority(ies) above the level of the healthcare facility managers and includes National and District Programme Coordinators in the public sector or corporate structures in the private sector including structures such as head office, district office, programme-specific committees and any other structures that may exist.
Documented evidence is required of a process through which the personnel of the healthcare facility are informed of the responsibilities of the programme's governance structure, for example during orientation and induction programmes, personnel meetings, information leaflets, memos, etc.
A mere organogram does not render this criterion compliant unless there is a concise description/listing of the key functions of the relevant structures as reflected in this criterion.
Also take note that some of this information may be contained in Acts, Regulations or Directives. In the private sector this information may also be published as a corporate document or on the organisation's website.

1.1.1.2. There is an organisational chart or document that describes the lines of authority and accountability between the national programme governance structure and the districts' health management teams.

Guideline statement:

This criterion requires an organisational chart of both the governance structure and the programme itself. These documents should also illustrate the relationship between the National and District Programme Coordinators and the next level of governance above him/her.
The phrase "lines of authority and accountability" requires more than merely a list of available posts or services rendered; it should be formulated in such a manner that it indicates to each member of staff who his/her direct supervisor is as well as his/her span of responsibility. The names of individuals do not need to be shown. As with any other official document, the organogram should be duly authorised (dated and signed).
The titles/post designations of those responsible for governing will automatically be displayed on the organogram provided it is drawn up correctly. This information can also form part of the documentation referred to in 1.1.1.1.
Detail about healthcare Programme Coordinators may also be offered in other documents such as position descriptions, delegations, performance agreements, etc.

1.1.1.3. Those responsible for governance (MOH level) approve and make public the programme's mission statement.

Guideline statement:

This section (1.1.1.3 to 1.1.1.11) requires documented evidence of the involvement of the governance structure in the stated activities.
There should be a standardised way in which all the different programmes carry out these functions. Therefore, the official documents in 1.1.1.1, 1.1.1.2 and 1.1.1.4 should guide the assessment of systems and processes in relation to the manner in which these responsibilities are carried out. The public display of the mission statement, for example on the health department's website or printed information leaflets, will ensure that it is known to personnel and patients alike.

1.1.1.4. Those responsible for governance set the goals for improving the mental health of all people living in the country through specific programme objectives.

Guideline statement:

Evidence of this may include the National Strategic Plan and related M&E (Monitoring and Evaluation) Framework as well as the programme's mission and scope of service.

1.1.1.5. Those responsible for governance (MOH&W level) ensure approval of strategic policies and strategic plans to operate a Mental Health Services programme.

Guideline statement:

Those responsible for governance are responsible to formulate the legislation, regulation and standards applicable to the programmes' services offered by healthcare facilities. Evidence of this may include policies and plans or minutes of meetings where these documents are approved.

1.1.1.6. Those responsible for governance (MOH&W level) approve the budget and allocate resources required to meet the programmes' mission.

Guideline statement:

An approved budget should be available in the management documentation. There should be evidence of the allocation of resources in accordance with the approved budget. The requirements and inputs from all levels of the programme, including facility level, are considered when the budget is drafted.

1.1.1.7. **CRITICAL** Those responsible for governance (MOH&W level) appoint the national programmes' senior coordinator(s).

Guideline statement:
The appointment letter or equivalent for the senior coordinator will provide the evidence for this requirement.

1.1.1.8. Those responsible for national programme governance receive and act upon reports (measurement and evaluation data) of the programme, at least quarterly.

Guideline statement:
This refers to the quality performance requirements included in the strategic plan.

1.1.1.9. Those responsible for national programme governance receive and act upon reports on the programmes' risk management data at least quarterly.

Guideline statement:
This refers to the risk management requirements included in the National and Programme strategic plan and should consider the following risks as a minimum:
• Stakeholder risk
• Reputational risk
• Compliance risk in relation to legislation
• Ethics risk
• Sustainability issues
• Activities with regard to corporate social investment
• Human and financial capital to sustain its activities

1.1.1.10. Those responsible for national programme governance evaluate the performance of the programmes' senior coordinators at least annually.

Guideline statement:
Documented evidence of this process should be made available to confirm compliance.

1.1.1.11. Communication and cooperation between the national programme's governance structure, health district programme management, referral and private hospital boards/management and the catchment population is established.

Guideline statement:
Evidence of this communication and cooperation will include minutes of meetings with Health District Programme Coordinators, referral hospital management teams, private sector representatives or evidence of other communication such as letters received and considered at meetings and information brochures printed for the general public.

1.1.1.12. **CRITICAL** The effectiveness and performance of the national programme governance structure is evaluated at least annually.

Guideline statement:
This should be achieved through the programme's M&E framework. The indicators for evaluation of the performance of the programme's governance structure should be included in the documentation in 1.1.1.4. Documented evidence of such evaluations should be made available.

1.2. Management of the Mental Health Services programme (National Programme Coordinator level)

1.2.1. A Programme Coordinator is responsible for operating the national Mental Health Services programme within applicable laws and regulations.

Intent of 1.2.1

This Performance Indicator addresses the standards that are applicable to the *National Programme Coordinator's* management structure.

A National Programme Coordinator is appointed by the governance structure (MOH&W) to be responsible for the overall national strategic operation of the programme. These responsibilities should be documented and known to the personnel of the programme at all levels. The individual appointed to carry out these functions should have the education and experience to do so.

The National Programme Coordinator is assigned the responsibility of ensuring that the policies approved at governance level are implemented in the health districts as well as public and private healthcare facilities that render programme-specific services.
In addition, this level of leadership is responsible for ensuring that systems of administration and organisation are in place to support the provision of excellent patient care within the individual health

districts. This includes the appointment of designated Health District Programme Coordinators for the priority programmes, data support teams and availability of clinical support systems in each district.

The criteria for this standard are scored according to the survey findings throughout the health districts. The volume and severity of identified deficiencies in related service elements will determine whether the criteria are penalised and to what extent.

1.2.1 Criteria

1.2.1.1. The National Programme Coordinator for the programme has the education and experience to match the requirements in the position description.

Guideline statement:

Compliance is to be assessed against the requirements set out in the position description.
Evidence could be found in a copy of the advertisement, interviewing notes or the corporate guideline on the filling of this position.

1.2.1.2. The National Programme Coordinator manages the strategic operation of the programme, including those responsibilities described in the position description.

Guideline statement:

This criterion is assessed based on the evidence of effective programme management found throughout the districts during the survey. This criterion is automatically scored PC in situations where the position has been filled temporarily (acting capacity) for longer than six months.

1.2.1.3. The National Programme Coordinator coordinates the development and distribution of policies for programme management and implementation functions.

Guideline statement:

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.
In general, the policies or procedures should identify:
• Quality assurance considerations for relevant support services (laboratory, radiology, CSSD, equipment maintenance, supply chain management)
• Occupational Health and Safety (for example radiation protection and safety, post exposure prophylaxis)
• Medication management and safety
• Hotel services standards
• Infection prevention and control policies

Policies relevant to the individual clinical programme in general should identify:
• Special consent considerations
• Programme-specific monitoring and evaluation requirements
• Programme-specific pain management and assessment
• Special qualifications or skills of personnel involved in the care process
• Availability and use of resuscitation equipment and medication
• How planning for programme operations will occur (staff planning, service continuity)
• 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

This criterion is assessed on all the policies required for implementing and achieving the programme goals and includes corporate, national and district matters. This criterion is not scored down for deficiencies that derive from the level of individual departments. However, the final rating of this criterion should be in line with the overall level of availability of the policies and procedures at district and facility levels.
Policies unique to a specific programme, for example training requirements are further detailed in SE 2 and 3.

1.2.1.4. The National Programme Coordinator monitors compliance with applicable laws, regulations and programme-specific policies.

Guideline statement:

This criterion will be scored in line with the evidence of implementation and compliance as per the data reported within the M&E framework.

1.2.1.5. **CRITICAL** The National Programme Coordinator oversees, coordinates and performs programme inspections within districts and healthcare facilities.

Guideline statement:

This requires documented evidence for whatever inspections may have been conducted and depends on programme-specific requirements.

1.2.2. The National Programme Coordinator implements processes to manage and control the programme.

Intent of 1.2.2

The role of the National Programme Coordinator is to provide administrative leadership and clinical guidance for the programme's service coordination and improvement initiatives. He/she coordinates mobilisation of the many stakeholders who contribute to the efforts and provides the necessary resources and staff to support the initiatives.

Referral and private hospitals are not part of the District Health Management Teams' responsibilities with regard to resources and staff, but must be included in the communication strategy and should be held accountable for clinical protocol implementation, audit and submission of relevant data.
He/she should consider the business case for care coordination initiatives (i.e., quantify the cost savings from specific risk mitigation strategies).

The criteria for this standard are scored according to the survey findings throughout the national health districts. The volume and severity of identified deficiencies in related district and facility level service elements will determine whether the criteria are penalised and to what extent.

1.2.2 Criteria

1.2.2.1. The National Programme Coordinator guides the District Health Management Teams in meeting the programme's mission, goals, and objectives.

Guideline statement:
Evidence can be in the form of reports and/or minutes of meetings between the National Programme Coordinator, Health District Programme Coordinators and referral and private hospital representatives.

1.2.2.2. The National Programme Coordinator determines the programme related care, treatment, and services it provides at different levels of care.

Guideline statement:
There has to be a generic plan that describes the type of programme-specific services that are provided/available at each level of care from health post through to referral and private hospital level.

1.2.2.3. The National Programme Coordinator implements processes to manage and control human, financial and other resources required to deliver programme-specific services.

Guideline statement:
This is assessed against the District Health Management policy framework and evidence of implementation thereof. The criterion score is derived from the final assessment of criteria dealing with adequate supply and effective management of resources required for programme service delivery (medication, consumables, support services, etc.).

1.2.2.4. The National Programme Coordinator ensures that the required physical facilities, installations and equipment are available to provide the specified programme services.

Guideline statement:
Please note that the term equipment refers to all non-medical as well as medical equipment.

1.2.2.5. There is a documented procedure to guide the delegation of authorities within the programme.

Guideline statement:
The procedure should state the minimum experience and/or training requirements to perform the delegated task, for example the function of the programme Focal Persons.

1.2.2.6. **CRITICAL** The National Programme Coordinator ensures the implementation of risk management processes and activities.

Guideline statement:
This will be assessed based on the level of implementation and effectiveness of the risk management processes, i.e. analysis of programme-specific M&E framework data collected with appropriate actions to rectify identified deficiencies throughout the healthcare districts.

1.2.2.7. The National Programme Coordinator ensures implementation of processes for programme-specific quality management and improvement.

Guideline statement:
This will be assessed based on the level of implementation and effectiveness of the quality management activities i.e. analysis of data collected with appropriate actions to rectify identified deficiencies in all districts health services.

1.2.2.8. The National Programme Coordinator implements processes to monitor the quality of programme-specific clinical services.

Guideline statement:

This criterion's score should be derived from documented actions taken to address findings from aggregated scores obtained from collated and analysed M&E data as well as clinical audit reports from all health districts and healthcare facilities.

2.Operational Programme Governance, Management and Leadership (DHMT)

Overview of Operational Programme Governance, Management and Leadership (DHMT)

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, Information Technology (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 for 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.

Intent of 2.1.1

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 each 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.
CRITICAL

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.

Intent of 2.1.2

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

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 or 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.

Intent of 2.1.3

Laboratory services form an essential component of comprehensive mental health 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 a Mental Health Service 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. A Mental Health Service 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 Mental Health Service 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 must 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 must 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.

Intent of 2.1.4

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.

In order to provide reliable imaging services in remote clinics and hospitals within a health district, issues such as electrical power, patient transport and trained operators (radiologists and radiographers) must be addressed (Detail included in SE 3).

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.

2.1.4 Criteria

2.1.4.1. A Mental Health Service 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 Mental Health Service 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 referral schedule for a district wide diagnostic imaging system is implemented.

Guideline statement:

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

2.1.4.4. 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 must 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.

2.1.4.5. 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.

Intent of 2.1.5

Sterile medical instruments and supplies can prevent some of the most common infections acquired through wounds, surgical incisions, minor procedures, 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 must 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 must 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 to and from 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 must 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 surgical and obstetric 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.

Intent of 2.1.6

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.

It is imperative that all facilities that render 24-hour bed 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 as well as 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.

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

Guideline statement:
On-call services should be available at health posts and clinics for emergencies outside of operational hours 24/7. Transport should be available within a reasonable time. There should be recorded/documented evidence that the availability is randomly checked and recorded. Appropriate response time must 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.

Intent of 2.1.7

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 medication. 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 must 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. 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/documented evidence that the availability is randomly checked and recorded. Appropriate response time must 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.

Intent of 2.1.8

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 must 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.

Intent of 2.1.9

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 act 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 programmes’ 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.

2.1.10. The programme has access to Therapeutic (Clinical) support services.

Intent of 2.1.10

Although therapeutic support services such as, for example, Audiology, Physiotherapy and Genetic Counselling services are not a general basic requirement for Mental Health services, these services can prevent serious, permanent patient morbidity and should be available to individual patients on a referral basis. Referrals for diagnostic and counselling services which are usually available at district, referral and private hospital level should be done according to specific policies and require written consultation and referral agreements.

2.1.10 Criteria

2.1.10.1. Screening and referral guidelines for therapeutic and social support services consultation are available.

Guideline statement:
These documents are available at all facilities that render Mental Health services.

2.1.10.2. A list of service providers is available and distributed to facilities.

Guideline statement:
This will be confirmed during the facility visit.

2.1.10.3. Patients are screened and referred as per policies.

Guideline statement:
Compliance will be assessed as part of medical record review.

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.

Intent of 2.2.1

Policies, procedures, protocols, forms and guidelines for programme-specific clinical care must 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.
An example of programme-specific policies, procedures, protocols and/or forms could include (but is not limited to) the following:
• Dealing with Mental Health Emergencies
• Aggressive or Threatening Behaviour
• Duty to Warn/Report
• Child Abuse Reporting/Documentation
• Adult Abuse
• Suicidal Behaviour (including suicide calls) & Client Suicide
• Substance Abuse
• Eating disorders
• Client Autonomy
• Concerns with Client Capacity

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.

Intent of 2.2.2

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 patient's life. Training manuals provide guidelines for improving the quality of Mental Health services to both the patient and the family. When implemented, this will ensure that Mental Health 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 must be documented, tracked and analysed over time and indicators included in the programme's M&E framework.

Competent healthcare practitioners (nurses, midwives and doctors) will be able to think critically in emergency situations and make effective decisions based on solid knowledge and understanding of Mental Health care 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 must 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 which must be provided to the District Programme Coordinator. Where volunteers are used to support the programme, relevant orientation must 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 of the training programme 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.

Intent of 2.2.3

Programme leaders must 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 must 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, 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 a minimum of 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.

Intent of 2.2.4

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 must consider the requirements of the national programme-specific M&E framework. A data reporting system from districts to the National Programme Coordinator must 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 consider that most clinical care involves more than one profession. 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. CRITICAL 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 must 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 must be available.

2.2.4.4. CRITICAL 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 must 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 forms of communication) of discussions on the information and how this is taken into consideration to assist with decision-making processes. This must happen at all levels of the programme and not just at district management level 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. CRITICAL 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 various 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 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.

Intent of 2.2.5

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 must 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 Mental Health Service programme-specific incident categories for reporting should be determined at national programme level.

Programme leaders must 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 must 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 must be provided to all facilities.

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

2.2.5 Criteria

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

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, etc.
Documented evidence is required.

3.Programme Service Management and Delivery (Healthcare Facility level)

Overview of Programme Service Management and Delivery (Healthcare Facility level)

The World Health Organisation has identified mental, neurological, and substance use disorders as common in all regions of the world, affecting every community and age group across all income countries. While 14% of the global burden of disease is attributed to these disorders, most of the people affected (75% in many low-income countries) do not have access to the treatment they need.

Promoting mental well-being includes:

- tackling stigma, discrimination and social exclusion
- preventing mental health problems
- providing care for people with mental health problems
- providing comprehensive and effective services and interventions
- offering service users and carers involvement and choice
- rehabilitation
- including into society the people who have experienced serious mental health problems

The first step in establishing a Mental Health service programme is the development of protocols relating to:

- The levels of care to be provided
- A trained person available/on call 24/7
- The skills, training and competence required
- Adequate and safe building structures
- Availability of equipment, medication and support services

The Mental Health programme-specific service management and delivery standards define the performance expectations, structures and functions that must be in place at **individual facility and institutional** level for the clinical programme to succeed.

Standards are applicable to all private and public healthcare facilities providing Mental Health services.

The Performance Indicators in SE3 of the standards are arranged according to the Donabedian quality model of "Structure- Process-Outcome".

The Botswana Standards for Quality and Safety in the delivery of healthcare for hospitals and clinics and/or external international accreditation bodies' standards provide a solid foundation for the Mental Health Service programme-specific standards. The Mental Health Service standards set additional, specific requirements for achieving optimal outcomes in care.

It is therefore important to understand that all standards for relevant service elements such as management and leadership, human resource management, administrative support, pharmaceutical service, laboratory service, hotel services etc. in the Botswana Hospital and Clinic Standards apply

and could be assessed during a programme assessment should there be a need based on the identification of serious deficiencies.

A clear understanding and compliance with the Botswana standards should therefore be in place prior to implementing the programme standards.

Standards

3.1. Programme service management

3.1.1. The facility's clinical and managerial leaders are identified and are collectively responsible for defining the programme's human resource needs and creating the plans and policies needed to fulfil these needs.

Intent of 3.1.1

Health systems have not yet adequately responded to the burden of mental disorders; as a consequence, the gap between the need for treatment and its provision is large all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high income countries is also high: between 35% and 50%. (WHO – Mental Action Plan, 2013)

The facility's senior management, service and/or unit managers are ultimately responsible for the management of all services rendered including services related to a specific clinical programme. In addition, a designated individual (Focal Person), officially nominated in writing by the facility manager and/or the District Programme Coordinator, oversees the day-to-day functions of the programme. This individual must have received training as a Focal Person for the programme (train-the trainer) and, depending on the size and level of the facility, could be the facility manager, service manager, unit manager, senior clinician, registered nurse or other appropriately qualified professional.

The Focal Person position is not a new position, duties are rendered in addition to regular professional duties and responsibilities, however, the individual's line manager should allow for sufficient time to provide the necessary programme support (training, auditing etc.) and for attending programme meetings and other related activities.

The Focal Person is supported by an interdisciplinary team that includes individual professionals with expertise in and/or knowledge about the programme's specialised care, treatment and services to ensure that the Mental Health Service is patient centred, integrated and coordinated with the services provided by the facility and within the district.

Team members include, depending on the level of the facility, psychologists, psychiatrists, medical officers, family nurse practitioners, general nurses, occupational therapists, paramedics, community nurses and social workers.

The Mental Health Service team should actively participate in the development and design of the care, treatment and services provided by the facility.

3.1.1 Criteria

3.1.1.1. An appropriately qualified and experienced individual (Focal Person) has clearly defined responsibilities and accountability for all aspects of the service.

Guideline statement:

This criterion requires an organisational chart which illustrates the relationship between the Focal Person and leadership positions in the organisation. Responsibilities and accountabilities must be contained in a job description with clear performance indicators. Proof of qualifications and experience in Mental Health care and comprehensive Mental Health Service guidelines must be available. A document/letter, signed by the Focal Person, informing him/her of the additional designated responsibilities must be available in the personnel file.

3.1.1.2. The Focal Person compiles and provides reports to the District Programme Coordinator and/or programme leaders for feedback on a regular basis.

Guideline statement:

The Mental Health Service Focal Person in the facility is managed according to the facility's line-management structure but has the additional responsibility of reporting on the programme to the District Programme Coordinator. The manner of reporting should be determined by the Mental Health Service programme leaders, for example through monthly reports, referral facility cluster meetings (sub-district meetings), through the facility management structure etc. Frequency should be at least monthly. Documented evidence is required.

3.1.1.3. At least one qualified person is available at all times (medical practitioner or registered nurse) to participate and/or provide guidance in the management of mental health emergencies.
CRITICAL

Guideline statement:

This is dependent on the level of the facility and will be assessed by reviewing the off-duty schedule for nurses or the duty roster for doctors and on-call lists. The qualifications of personnel allocated to each shift will be reviewed to verify compliance with the requirement of the criterion.

3.1.1.4. An interdisciplinary programme team has been established and meets at regular intervals.

Guideline statement:

Representation on the team is dependent on the level of the facility and services provided. Documented evidence of team names and minutes of regular meetings is required.

Members include some or all of the following professionals and representatives from services relevant to the level of the facility:
• The facility's Mental Health Service Focal Person
• The facility's senior registered nurse or manager
• A qualified medical practitioner
• A psychologist
• A psychiatrist
• Radiology support services
• Registered pharmacist
• Laboratory support services
• Occupational health representative
• Dietetics
• Social worker
• An Occupational Therapist
• A Community nurse

3.2. Human resources management

3.2.1. Documented training and skills development systems are in place for Mental Health Service providers and are implemented.

Intent of 3.2.1

The facility's HR department, together with line managers, service managers, Focal Persons and programme leaders must determine the staffing norms, formal training needs and skills required within the facility to render a safe and effective Mental Health service at all times during the facility's operational hours.

The programme team should actively participate and support the facility and district programme leaders in the development and design of the care, treatment and services provided by the facility as well as the development of education programmes based on the needs of clinical staff and the catchment population served.

Some team members such as psychiatrists, psychologists, medical officers and allied professionals, who are full time employees at hospitals only, would also be responsible to support the programme with training, mentorship, out-reach and skills development at clinics and health posts within the hospital's referral network.

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.

Volunteers are not formal employees of the facility and should therefore not be allowed to work unsupervised in order to safeguard patient safety. They have to be fully orientated as to their functions within the facility and receive the necessary training with regard to, for example infection control,

patient safety, waste management etc.

3.2.1 Criteria

3.2.1.1. ROOT Minimum critical competencies required for any/all professional nurses, medical practitioners and other professionals providing basic, regular Mental Health care are identified and assessed.

Guideline statement:

A competency framework is designed to:
• Help to identify training needs within and across the health and social care workforce
• Enable organisations to design and provide training to a consistent model
• Help employers to draw up job descriptions
• Be useable in group training
• Support individuals' self-assessment of their own development needs
• Function as a guide for designing local care pathways and commissioning services

Each employee's ability to perform the listed critical competencies is assessed on an ongoing basis through observation and formal protocols by service and Unit Managers, Focal Persons, Mentors and other designees as required. This assessment is documented and shared with District Programme Coordinator.

Critical competencies include at a minimum:
• Performing a full assessment
• Use of current and new clinical equipment or technology
• Care practices that promote patient and family-centred care
• Clinical drills to help staff prepare for unanticipated complications or high-risk events
• Transferring or transporting of patients
• Safety and security of the patient
• Use of equipment required for resuscitation, ventilation and cardiovascular support
• Patient safety drills

Documented evidence (for example HR files, training data, minutes of drills and desk top exercises) is required.

3.2.1.2. Staffing norms are determined for the allocation of appropriately trained healthcare professionals required to meet the Mental Health Service programme's scope of care, treatment and level of services it provides at all times during official facility hours.

Guideline statement:

A list of names and duty roster with contact numbers of team members should be displayed in relevant service areas and units.
The list must be examined for evidence of adequate numbers of the various categories of personnel in relation to the type of patients, acuity levels, monthly visits etc.
In general, primary health care facilities which provide Mental Health Services are not in-patient facilities.
Depending on the nature and structure of the services, adequate medical and nursing staff must be provided to cover both scheduled specialist clinics and unscheduled patient visits.
As a minimum, a registered nurse should be on duty at all times.

3.2.1.3. The employees rendering Mental Health services have education, experience, training and certification consistent with the programme's scope of care, treatment and services.

Guideline statement:

Service and Unit Managers together with programme leaders are responsible for ensuring that all professional staff who render Mental Health services have received appropriate training and practice within their scope of professional licensure, certification and competency. The qualifications, training, experience and skills of staff who are rendering Mental Health services in the facility are evaluated on an ongoing basis by service and Unit Managers, Focal Persons, Mentors and other designees as required. Documented evidence in the HR personnel files is required.

3.2.1.4. Responsibilities and accountabilities of the employees rendering Mental Health services are defined.

Guideline statement:

Professional responsibilities depend on the level of facility and type of services rendered and are defined according to the programme's policies, protocols and regulations.
Within the team, additional responsibilities for mentorship and training, clinical audit, patient education programmes, data collection, monthly reports etc. assigned to individuals have to be identified and documented in the job description. Documented evidence in the HR file and minutes of meetings is required.

3.2.1.5. Mental Health Service specific orientation and training needs for designated healthcare professionals who render emergency Mental Health services are identified and communicated to the District Programme Coordinator.

Guideline statement:

Designated professional healthcare workers' ability to perform assessment, classification, effective triage, treatment, follow-up and counselling for all Mental Health Service patients are assessed and training needs identified. Information is regularly communicated to the District Programme Coordinator. Documented evidence in the HR files and minutes of meetings is required

3.2.1.6. Mental Health Service specific orientation and training for designated healthcare professionals who render emergency mental health services is implemented.

Guideline statement:

Designated professional healthcare workers responsible for rendering basic and comprehensive Mental Health care are fully trained as per national policy guidelines. If national policy guidelines have not been established, the World Health Organisation's Mental Health Gap Action Programme (mhGAP) must be used.
Documented evidence of a district and facility wide training plan and completion of training, including minutes of meetings and training certificates in the HR files is required.

3.2.1.7. Critical competencies of employees that render mental health services are assessed through observation on an ongoing basis. This assessment is documented.

Guideline statement:

Competencies of designated professional healthcare workers responsible for rendering basic and comprehensive mental health care are assessed by Unit Managers, Mentors, senior professionals, Focal Persons and other designated professionals. Observations and recommendations have to be documented through minutes of meetings, morbidity and mortality (M&M) meetings and shared with the District Programme Coordinator. This assessment is documented.

3.2.1.8. A mentorship protocol has been established.

Guideline statement:

Where possible, senior/experienced healthcare professionals are partnered with less experienced employees. Documented evidence must be provided.

3.2.1.9. Where volunteers are used, they have received the required orientation and training relevant to the functions that they perform within the facility.

Guideline statement:

A list with volunteer names and orientation/training received has to be available.

3.2.1.10. Where volunteers are used, they work under the guidance of the Facility Manager or his/her delegate in the employ of the facility.

Guideline statement:

Documented evidence must be provided.

3.3. Clinical practice guidelines, protocols and policies

3.3.1. Clinical practice guidelines and protocols are used to guide patient care and reduce undesirable variation.

Intent of 3.3.1

Detailed history taking and comprehensive physical examination are essential skills for all healthcare professionals to achieve good clinical practice outcomes. This requires competence, experience, continuous practice and sound clinical knowledge and skills.

Evidence based treatment protocols and clinical guidelines based on current best practice principles ensure that optimal treatment can be achieved through uniform approaches to specific aspects of patient care. Clinical practice guidelines provide a means for improving quality and assist practitioners and patients in making clinical decisions. Consideration should be given to providing guidelines for high risk, high volume and high cost conditions as these are the areas that represent the highest risk to patients and the facility. In addition, guidelines should be available for conditions which are rarely seen but may have severe consequences for patients if misdiagnosed or mismanaged.

Guidelines are found in the literature under many names including practice parameters, practice guidelines, patient care protocols, standards of practice, care pathways etc. Guidelines and protocols may be provided and/or endorsed by national programme directorates, international professional and advisory bodies for example WHO or developed locally by the interdisciplinary programme team.

Regardless of the source, the scientific basis of guidelines should be reviewed and approved by the clinical programme leaders and clinical practitioners before implementation. This ensures that they meet the criteria established by the leaders and are adapted to the community, patient needs and

hospital resources.

Protocols and guidelines must be available at all times to professional staff and service providers in the form of posters and manuals (paper based and/or electronic) and periodically updated according to documentation policies.

Documentation and record keeping must be comprehensive and of a high standard. Quality assurance through clinical audits, documentation audit, inspections and M&M meetings ensure that guidelines are adhered to and standards are achieved. Monitoring implementation of these guidelines provides the necessary information to ensure that the required standards of care are met for all relevant patients and services.

Clinical drills help service providers prepare for high risk events with a low rate of occurrence and subsequent debriefings, to evaluate team performance and identify areas for improvement, should be performed on a regular basis at least quarterly.

3.3.1 Criteria

3.3.1.1. Clinical practice guidelines and protocols required to meet the Mental Health Service programme's scope of care, treatment and level of services are available.

Guideline statement:
This includes all policies and protocols listed in criteria 1.2.1.3 and 2.2.1.2.

3.3.1.2. Clinical practice guidelines and protocols are based on international and national care guidelines, clinical evidence and mental health subject matter expert teams input.

Guideline statement:
If guidelines that are developed by international organisations (for example WHO) are used for mental health services, they should be adapted for patient profiles in the country.

3.3.1.3. The implementation of guidelines and protocols is monitored as part of a structured clinical audit.

Guideline statement:
Documented evidence of a formal clinical audit system must be provided.

3.3.1.4. Results of facility audits are provided to and analysed by the facility's programme team and provided to district programme leaders.

Guideline statement:
Documented evidence of analysed results and action plans must be provided.

3.3.1.5. Regular M&M (Morbidity and Mortality) meetings to discuss adverse patient outcomes and complications take place.

Guideline statement:
Documented evidence such as minutes of meetings and required actions must be made available.

3.3.2. Programme-specific policies and procedures and/or forms are available and implemented to support its practices across the entire programme care continuum within the facility.

Intent of 3.3.2

In addition to all interdepartmental and departmental policies that guide general service delivery in the facility, the specific programme related policies as listed in **SE 1** (1.2.1.3) and **SE 2** (2.2.1.2) must be distributed by the district programme leaders and made available to all personnel involved in mental health care. For policy implementation and service delivery to be efficient, a working framework needs to be developed with clear roles and responsibilities for each person in the team. Mental health care has a high risk for adverse events and it is therefore important to ensure that personnel have a clear understanding of definitions, standardised terminology and content of the policies.

3.3.2 Criteria

3.3.2.1. Policies, procedures and forms required to meet the mental health service programme's scope of care, treatment and level of services are available and implemented.

Guideline statement:

This refers to the policies that are relevant to the level of care provided at the specific facility. Evidence will be verified during the patient and practice record audit and personnel interviews.

3.3.2.2. All identified mental health specific forms and documents are fully completed and up to date for each patient.

Guideline statement:

Evidence will be verified during the patient and practice record audits.

3.3.2.3. In-service training is provided to personnel to ensure that they understand the intent and content of the policies and procedures.

Guideline statement:

Where policies and procedures refer to patient care, compliance will be measured against the relevant areas in the patients' records during the record audit process.
By implication, if the policies are implemented, personnel can be considered to have been trained and this criterion will be scored accordingly. This training could take the form of formal in-service training, introduction to policies during initial orientation, discussions at departmental meetings, case studies etc.
Documented evidence such as a training plan, training records, staff interview, patient record audits is required.

3.4. Facility infrastructure, furniture and utilities

3.4.1. Functional facilities are available to provide safety and comfort for patients, visitors and personnel.

Intent of 3.4.1

The design, construction, maintenance and safety of all healthcare facilities must meet current local and national building codes for healthcare facilities, zoning regulations, fire safety regulations and equipment needs. All general standards for patient consultation areas and in-patient units as per the Botswana National Healthcare Standards for Hospitals and Clinics and/or other international accreditation standards must be met.

All facilities providing mental health care regardless of size and resources, must comply with these requirements as part of their responsibilities to their patients, families, personnel and visitors.

The Focal Person needs to work closely with the facility and programme leaders to ensure that facilities and equipment required for the programme are adequate. Management and programme leaders are kept informed of inadequate facilities, additional equipment requirements and the current state of facilities and equipment.

3.4.1 Criteria

3.4.1.1. The lay-out of the facility allows for effective flow and safety of patients.

Guideline statement:

Hallways must be adequate to permit easy ingress and egress for ambulance stretchers and wheelchairs. Doorways must be wide enough to comfortably accommodate a normal hospital bed. There must be unobstructed, rapid access to and from consulting rooms to the building exit where emergency transportation vehicles may be accommodated.
Areas for record storage, administrative staff and minor laboratory tests shall be provided in a space separate and distinct from public areas.

3.4.1.2. There is a waiting area with adequate seating.

Guideline statement:

The reception or waiting area should be adequate to meet the needs of patients and their families for space and comfort.

3.4.1.3. There are areas for personnel to obtain and give confidential information to patients in privacy.

Guideline statement:
Consultation areas for mental health care shall be distinctly separate from the public areas and provide adequate auditory and visual privacy. Where patient interactions must take place where no separate consultations rooms are available, the area should be partitioned with a curtain and far enough away from the public to guarantee privacy.

3.4.1.4. There are separate toilet/washroom facilities for staff and for patients/visitors.

Guideline statement:
Separate toilet facilities should be provided for patient's family and personnel of the facility.

3.4.1.5. There is an area that can be allocated for patients that need to be transferred to an in-patient facility.

Guideline statement:
Mental health care is intended as a primary service and no in-patient accommodation is required. In cases where a patient needs urgent care, referral or transport to a secondary or tertiary care facility, appropriate accommodation must be provided while the patient waits for transport.

3.4.1.6. Separate storage facilities are available for food products, medication and other consumables and equipment.

Guideline statement:
Storage facilities for food, medication, linen, other consumables and equipment are separated and access is controlled. Easy retrieval of items is possible during an emergency. Multiple storage and utility space is needed. Large facilities need a separate room for each function whereas small facilities may combine space or utilise a cupboard. The following areas are required:
• A lockable drug trolley or cupboard to store medication.
• A Clean utility area to store consumables and supplies
• A linen cupboard for clean linen
• An equipment store to clean and keep equipment ready for use
• A dirty utility area for dirty linen
• A cleaner's room to place and keep cleaning materials
Fridges for medication, vaccines and nutritional products must be separate and kept at the correct temperatures.

3.4.2. The required furniture and utilities are available and functioning appropriately.

Intent of 3.4.2

In order to provide safe patient care, each unit requires adequate resources. An assessment is made as to whether the facility has the required furniture and plant equipment.

An uninterrupted source of safe water which is piped into the facility should be available at all times. Proper ventilation and air conditioning is vital for the prevention and treatment of infections and diseases. The facility should be equipped with a heating, ventilation and air conditioning system in good working order. Normal household lighting must be available in common areas. Consultation and treatment rooms must have adequate examination lights and there must be provision for automatic emergency lighting during a power failure.

3.4.2 Criteria

3.4.2.1. The required furniture for mental health services is available and functional.

Guideline statement:
Furniture includes examination couches, tables and chairs. Furnishings shall be constructed of materials that are fire retardant (or are made so) and can be easily cleaned with appropriate antiseptic solutions.
Where indicated, mosquito nets must be available. Furniture must be adequately maintained and proof of an efficient preventive maintenance system and register must be available.

3.4.2.2. Safe handwashing facilities are available.

Guideline statement:
An uninterrupted source of piped, clean, hot and cold water should be available at all times. Hand basins, liquid soap and paper towel dispensers should be installed in all procedure and consultation rooms. Where basins are not available in all areas or rooms, hand sanitising dispensers must be available.

3.4.2.3. Adequate room lighting is available.

Guideline statement:
Depending on the level and location of the facility, various sources of lighting are used such as wired electricity, generators and solar power. Back-up lighting such as generators, battery lamps or gas lamps with adequate mantels and full gas cylinders could be considered in rural areas with inconsistent electricity supply due to power cuts. The power source for lighting must be adequate to safely perform treatment and emergency procedures.

3.4.2.4. There is a functional heating, cooling and ventilation system.

Guideline statement:

Depending on the level and size of the facility, this could be a window fitted air conditioner, split air conditioner, packaged air conditioner or central air conditioning system. In rural areas where no mechanical ventilation system is installed, proof must be provided that the required airflow and temperatures are achieved. Evidence of documented monitoring is required.

3.5. Medical equipment, instruments and supplies

3.5.1. Medical equipment, instruments and supplies required by the programme in order to support the scope of care, treatment and services provided are available.

Intent of 3.5.1

The availability of essential medical equipment, instruments and supplies plays a major role in delivering high-quality mental health services. The medical equipment manager is an essential member of the programme team and must ensure that relevant equipment is readily available, in working order and routinely checked according to facility policy. Periodic maintenance checks documenting functional competency and availability for each item must be documented and available on the premises of the facility. Equipment must be accessible in an area convenient for emergency application. An equipment bank for temporarily replacing essential, broken equipment should be available from a central facility in the district. Turnaround times for ordering and repairs should be determined, documented and monitored. Where a healthcare facility/medical practice does not have access to a central sterilising service (CSS), arrangements are in place to obtain sterile supplies.

An adequate supply of patient records and relevant forms must be available for existing and new patients to ensure continuity of care.

3.5.1 Criteria

3.5.1.1. Medical equipment, instruments and supplies relevant to mental health service guidelines are available according to the most current protocol.

Guideline statement:

The requirements at minimum include:
• Resuscitation trolley • Paediatric and adult airways
• Examination bed • Gloves
• Thermometers • Diagnostic set
• Sphygmomanometer • Stethoscope
• Oxygen saturation monitor/s • Oxygen & nasal prongs
• Suction and suction catheters • IV Cannulas
• IV giving sets • Injection packs
• Immunisation pack • Syringes/needles
• Water for injection • Haemoglobin testing system
• Glucometer • Rapid HIV test
• Rapid Malaria test • Lab specimen collection tubes
• Urine analysis test strips • Solutions (antiseptics)
• Adhesive tape • Weighing scales
• X-ray viewer • Side lamps
• Trolleys • Wall clock or timing device
• Mosquito nets (where required) • Linen
• Cups, spoons, measuring/mixing utensils • Sterilising equipment
• Medication fridge • Vaccine fridge
• Patient records • Charts, booklets and recording forms
• Stationary

3.5.1.2. A preventive maintenance programme for all equipment and instruments is in place.

Guideline statement:

Documented evidence as per Botswana National Health Quality Standards must be provided.

3.5.1.3. Deficiencies and needs are regularly documented and communicated by the Focal Person to facility and programme leaders.

Guideline statement:

Documented evidence, for example repair requests, must be provided.

3.5.1.4. Turnaround times for ordering and repairs are monitored and analysed.

Guideline statement:
Documented evidence must be provided.

3.5.1.5. Staff are trained and competent in the use of specialised medical equipment.

Guideline statement:
Documented evidence must be provided.

3.6. Hotel services

3.6.1. Systems for food and nutrition management are implemented.

Intent of 3.6.1

If food is prepared on site, the kitchen shall include at minimum a designated refrigerator, cooking stove, sink, storage cabinets, disposable dishware and eating utensils and counter space for the convenience of personnel, volunteers and/or patient's families to prepare snacks.

In facilities without an inpatient unit, food may be prepared for patients that have travelled long distances. In all instances, standards and criteria for safe and hygienic food preparation apply.

Where food is provided by volunteers or families from outside the health facility, observation, advice and education should be provided relating to nutrition and hygienic food preparation. Particular attention should be paid to hand washing, the use of clean utensils and the control of flies and other vectors.

Where meals are prepared in central kitchens (such as hospitals) and transported to clinics, policies that address risks and quality criteria such as transport methods, turnaround times from kitchen to clinic, temperature and quality monitoring and 'cook-chill' (a method of food preparation used by caterers, in which cooked dishes are chilled rapidly and reheated as required) protocols must be available and implemented.

3.6.1 Criteria

3.6.1.1. A functional kitchen with equipment appropriate for the level of the facility and programme services rendered is available.

Guideline statement:
The quantity and type of equipment must be determined based on the programme needs, number of meals required and the plating procedures. Equipment such as a kettle, stove and/or microwave should be available.

3.6.1.2. Hygiene practices for food preparation and serving methods are implemented.

Guideline statement:
Personal protective equipment (PPE) must be readily available and food handlers and persons not normally employed in the food service must wear personal protective clothing while in the area. Education on PPE, waste management and hand washing procedures is provided. Notices displaying procedures to this effect must be available.
Food waste is placed in covered containers and removed without delay from places where food is prepared.

3.6.1.3. Where families or others provide food, they are educated about the patient’s diet limitations.

Guideline statement:
Documented evidence must be available in the patient’s record.

3.6.1.4. Quality and safety of food provided and transported from a central kitchen is monitored.

Guideline statement:
Documented evidence must be provided.

3.6.1.5. A clinical dietitian is available for consultation and development of meal plans.

Guideline statement:
Documented evidence must be provided.

3.6.2. Systems for linen and laundry service management are implemented.

Intent of 3.6.2

Inadequately cleaned and/or contaminated linen and clothing is an important contributing factor to hospital acquired infections, sepsis, morbidity and mortality. Linen, clothing and blankets should be light in colour since dark coloured linen will not show stains and dirt easily and may contribute to infections.

Facilities must have sufficient supplies of clean linen, disposable linen savers, blankets and pillows at all times. Where the laundry service is within the facility, it is designed to allow for safe and effective processing of laundry. Adequate utilities and facilities must be provided for separate sorting, processing and storage of clean and dirty linen. The capacity of the laundry must be sufficient to function 24/7 if required and contain washer and dryer equipment maintained in good working order.

Where the service is out-sourced, the arrangement between the facility and the off-site laundry clearly states the responsibility for sorting, counting, collection and delivery of linen.

Departmental and service managers are primarily responsible for the management and leadership for linen and laundry services at departmental and unit level, while the service requires clear, designated leadership from a suitably qualified individual. Evidence of support and oversight from the individual or team responsible for Infection Prevention and Control must be available.

3.6.2 Criteria

3.6.2.1. Linen and laundry supplies and facilities are adequate for the level of service and volume of patients. **CRITICAL**

Guideline statement:

Facilities, equipment and adequacy of volumes, types and colour of linen and linen savers will be assessed through observation and patient and staff interviews.

3.6.2.2. Policies and procedures ensure that personnel receive guidance in the functions performed.

Guideline statement:

Policies include:
- Handling of soiled and infected linen
- Separation of the laundry into areas for clean and soiled laundry
- Wearing of protective clothing
- Searching used linen for sharps and other items
- Marking of linen to identify ownership

3.6.2.3. A system is in place to ensure that departmental policies and procedures are known and implemented.

Guideline statement:

This will be determined through interviews and observations. Documented evidence of signed, current policies is required.

3.6.2.4. Patients and families have received orientation on sanitary requirements for linen and clothing and infection prevention and control procedures.

Guideline statement:

Documented evidence is required and will be confirmed during the patient record audits.

3.6.3. Systems for the management of housekeeping services are implemented.

Intent of 3.6.3

Implementation of good housekeeping practices based on sound policies and protocols are essential for providing a safe and clean environment for patients, employees and visitors and are one of the

most important tools for reducing morbidity and mortality in mental health service patients.

Irrespective of whether the service is contracted out or rendered by facility employed personnel, an education programme for housekeeping staff to assist them in understanding effective methods of cleaning in different service areas and the importance of their work in preventing healthcare acquired infections must be implemented.

Policies must define the specific items to be cleaned, tasks to be performed within different locations, frequency of cleaning, method of cleaning, disinfection agents, supplies needed and procedures to be followed.

The frequency and method of cleaning is determined by the surface to be cleaned, amount and type of soiling present, amount of activity in the area, risks to patients and the purpose of the area.

Cleaning procedures shall be completed on a scheduled basis (usually daily) and must clearly differentiate between low-risk areas such as offices and staff tea rooms and high-risk areas where contamination is expected, for example procedure rooms, consultation rooms, bathrooms and areas where blood, body fluids, secretion and excretion spills occur. Surfaces that are frequently touched by the hands of healthcare workers and patients such as call bells, surfaces of medical equipment and knobs for adjustment or opening, require frequent cleaning.

Warm, soapy water is adequate for cleaning areas not directly involved in patient care, for example offices and duty rooms. A disinfectant is required when cleaning high-risk areas with a large number of pathogens. Housekeeping personnel should use the same precautions to protect themselves during routine cleaning that they would use for terminal cleaning. Masks are not needed unless the room was occupied by a patient for whom there were airborne precautions.

Adequate, safe storage such as a lockable room or cupboard, used specifically for this purpose must be available for cleaning equipment, materials and chemicals.

3.6.3 Criteria

3.6.3.1. There is an adequate number of suitably trained housekeeping personnel to provide a safe and effective service.

Guideline statement:
Staffing needs are determined by the type of services rendered and volumes and types of patients served. Documented evidence is required.

3.6.3.2. Programme leaders and facility managers ensure that housekeeping personnel (contracted or facility employed) participate in relevant orientation and in-service training programmes (for example infection control, health and safety).

Guideline statement:
Documented evidence such as training registers and personnel files is required.

3.6.3.3. Housekeeping policies and procedures relevant to cleaning of various service areas and equipment are available and implemented.

Guideline statement:
A manual with the required policies and procedures based on recognised practices must be available.

3.6.3.4. Spill kits for cleaning hazardous material and blood and body fluid spills are available.

Guideline statement:
Treatment and service areas should have adequate stock of pre-packed spill kits for hazard free blood and body fluid spill cleaning.

3.6.3.5. Adequate and secure storage areas are available for equipment and chemicals.

Guideline statement:
Cleaning trolleys and chemicals for cleaning are safely stored out of reach of patients, children and visitors.

3.7. Pharmaceutical services

3.7.1. Medication and drug management systems are implemented.

Intent of 3.7.1

Applicable laws and regulations are incorporated into the operations of the medication management system used in the facility.

Each healthcare facility has the responsibility of identifying the individuals with the necessary knowledge and experience, who are permitted by laws, regulations or registration to prescribe or order medication. Medication use is organised throughout the facility to meet the needs of patients. Depending on the type of facility, the responsibility for medication management may be assigned to a pharmacist, a senior staff member such as the facility manager or professional nurse.

Emergency medication used for resuscitation purposes may be kept in an emergency bag in facilities without crash carts. The same principles for checking and controlling this medication must be applied as per hospital standards.

Facility pharmacists, dispensary personnel, service/unit managers and programme Focal Persons are responsible for facility level stock and quality management and communication with programme leaders.

Equipment such as designated medication fridges and medication cool bags must be available and temperatures must be monitored.

Safe administration of medication requires a strict and comprehensive protocol. The physician, nurse and other care providers work together to monitor patients on medication. Patients and/or their caregivers are educated to understand and monitor the effects of the medication that they are taking and to administer them at home. The purposes of monitoring are to evaluate the response to medication, to adjust the dosage or type of medication when needed, and to evaluate the patient for adverse effects.

3.7.1 Criteria

3.7.1.1. A designated, registered professional has clearly defined responsibilities and accountability for all aspects of the pharmaceutical service.

Guideline statement:
The responsible individual could be a pharmacist/pharmacy technician (under the supervision of a pharmacist), or registered professional nurse. The required professional registration and certificates must be available in the HR file and responsibilities must be clearly defined in the job description and signed by the staff member.

3.7.1.2. Cooperation exists between the programme Focal Person, programme leaders and the pharmacy and/or other relevant staff in the facility to ensure safe prescribing, ordering, storage and dispensing of programme-specific medication.

Guideline statement:
Documentation such as minutes of multidisciplinary meetings, analysed data from patient file audits, emergency trolley/tray/pack audits and inspection reports of medication storage areas and dispensaries is available and used when determining stock levels required for essential mental health service programme medication and drugs at individual facilities.

3.7.1.3. There is a collaborative effort to develop and monitor additional medication policies and procedures specific to the mental health service.

Guideline statement:

Policies specific for the mental health service programme must include at a minimum:
• Safe use of all drugs in mental health care (including tranquilisers, sedatives, antipsychotics and antidepressants)
• Complete drug list with protocols
• Pain management
• Administration of injections and intravenous infusions in the absence of a medical practitioner
• Emergency medication required to initiate and maintain resuscitation
• Preparation, handling, storage and distribution of parenteral and enteral nutrition products
• Monitoring of mental health service patients for the effects of medication.
• Dispensing of medication and patient education at the time of the patient's discharge.
• Antibiotic usage monitoring
• Management of mental health service records and statistics.
All policies should be signed by programme as well as pharmacy managers.

3.7.1.4. CRITICAL Functional pharmaceutical refrigerators and/or cool bags designated for storage of vaccines and other temperature-sensitive medication are available and monitored to ensure maintenance of the cold chain.

Guideline statement:

Refrigerators must comply with local laws and regulations for safe medication storage. No food, beverages or other items may be stored in the refrigerators. Temperature must be monitored at least twice daily during the facility's operational hours with thermometers that are approved for the purpose, easily readable, in proper working condition and accurate within a range of plus or minus two (2) degrees.
Cool bags for transporting vaccines and medication to health posts must have cold packs, buffer packs and a digital thermometer.

3.7.1.5. CRITICAL Medication identified for special control by legislation or policy is securely stored and accurately accounted for in accordance with Botswana laws, regulations or policy.

Guideline statement:

Controlled medication must be stored in a cabinet of substantial construction, for which only authorised personnel have the keys.
Control measures generally include the keeping of medication registers for these items.
Compliance will be measured against national control regulations.

3.7.2. There is a system to ensure access to appropriate medication at all times.

Intent of 3.7.2

Patients and customers must be able to receive the drugs and medication that they need in emergencies and/or at appropriate, regular intervals close to the places where they live.

Standards for transport and supply chain support systems require that every healthcare facility that renders mental health service care is adequately supplied with the necessary drugs, medicines, consumables and vaccines at all times. (SE 2.1.6)

The WHO defined essential medicine and drugs for primary healthcare and hospitals are included in the Botswana Medicine Formulary and should be available in all facilities.

Facilities that render mental health services must have adequate and appropriate supplies of medicines and drugs for routine and emergency mental health care at all times.

Individuals who are permitted to prescribe or order medication in emergency mental health situations must be identified and privileged as such.

Policies and procedures define the documentation required for ordering and prescribing medication and for verbal medication orders.

Regularly updated medication protocols for specific mental health situations, legal authorisation of

professional staff and benefits and risks to the individual patient must be instantly accessible and implemented taking into account the level of facility and services rendered at the facility.

3.7.2 Criteria

3.7.2.1. Appropriate drugs and medication are stocked and readily available for ordering and prescribing according to the Botswana drug formulary and protocols and the facility's level of care, mission, patient needs and services provided.

Guideline statement:

Scoring will depend on the availability and appropriateness of medication to be able to treat all conditions relevant to the level of care. The recommendations of professional national and international organisations or alternate authoritative sources guide the provision and use of medication and drugs used in mental health care.

3.7.2.2. There is a process to ensure the safe and legal prescribing/ordering of medication.

Guideline statement:

All the relevant standards in the Botswana and other international accreditation bodies' Pharmaceutical Service as well as Botswana Laws and Regulations apply.
The Nurses and Midwife Act 1995 specifically regulates the circumstances under which registered nurses are allowed to prescribe and administer certain medication and drugs in clinics without medical officers and/or when life threatening emergencies exist while the Drugs and Related Substances Act 1992 grants legal authority to registered nurse professionals to prescribe specific drugs from the Botswana National Drug Formulary.
The programme leaders must ensure that the relevant individuals are identified, adequately trained and officially privileged through professional certification. Documented evidence is required in the job description and HR file.

3.7.2.3. The facility's professional staff adhere to laws, regulations and approved practice guidelines when dispensing and administering medication.

Guideline statement:

Medication and drugs must be administered according to current Botswana laws and regulations. Copies of the relevant documents must be available in all facilities.
Compliance will be assessed during the patient record audits.

3.7.2.4. Medication is stored, dispensed and administered in a manner that ensures safety and effectiveness.

Guideline statement:

All the relevant standards in the Botswana and/or other international accreditation bodies Pharmaceutical Service SEs as well as Botswana Laws and Regulations apply. Policies and protocols that address issues such as:
• Management of high-alert medication
• Management of emergency medication trolleys and/or trays
• Administration of injections and IV infusions
• Labelling of medication, syringes and IV solutions
• Limitation of practice
• Administration of anaesthetics
• Management of dangerous and habit-forming drugs
• Separation of sound-alike, look-alike drugs and different dosages of the same drug
• Prevention and management of severe drug reactions, adverse events and medication errors
should be in place and implemented.

3.7.2.5. Medication orders must be recorded in the patient's file and signed by the ordering person with his/her name, signature, designation, date and time.

Guideline statement:

Compliance will be assessed during the patient record audits.

3.8. Laboratory services

3.8.1. Adequate laboratory services are available 24/7.

Intent of 3.8.1

Any facility that offers mental health care must have the ability to conduct on-site, point-of-care, basic laboratory tests for routine conditions, taking into account the characteristics and needs of the population served.

A laboratory service must be available for referral tests, as well as the oversight of quality control of point-of-care tests.

In a health post or clinic, investigations are usually performed by trained nurses. A designated laboratory area may be a counter in the service area or a separate room equipped with the necessary

and functioning equipment and reagents needed to conduct the tests. Protocols, guidelines and/or posters demonstrating correct procedures for performing on-site and referred tests should be available in the service area.

Laboratory request forms should be standardised, comply with Botswana standards and provide information regarding the acuity of the patient.

Hospital and independent referral laboratories must have the capability to immediately receive, process, and report results 24 hours a day, 7 days a week.

Realistic turnaround-times that consider distance from the laboratory, transport services and volumes received should be agreed upon and monitored for individual facilities.

Designated district laboratory staff must provide oversight to clinics and health posts and submit regular reports for monitoring the quality of equipment, specimens and results. Suitable backup systems and plans should be in place including a system and protocol for reporting and responding to critical results.

3.8.1 Criteria

3.8.1.1. The facility provides point-of-care laboratory testing essential to the immediate classification and treatment of the patient.

Guideline statement:

The necessary reagents, kits and equipment for the following on-site investigations should be available in all service areas of any facility that renders mental health care and should include:
• Chemical examinations of urine by stick or tablet methods or both (including urine ketones)
• Haemoglobin or haematocrit
• Blood sugar
• Rapid test kits for HIV, Syphilis, Malaria (in endemic areas)
• Urea and electrolytes
• Thyroid function test (TFT)

3.8.1.2. The facility has access to 24/7 laboratory services.
CRITICAL

Guideline statement:

Every facility must be included in a coordinated district laboratory referral system/plan that considers transport of specimens and patients, designated dates/days for routine testing and emergency situations. Facilities where these services are available must be identified and contact numbers available and posted. Documented evidence is required.

3.8.1.3. Protocols for requesting investigations required for the management of specific mental health conditions and complications must be available.

Guideline statement:

The protocols should include the specific investigations required as per clinical guidelines, the appropriate specimen collection procedure, the designated referral laboratory and additional patient information required. Examples include full blood counts, blood cultures, toxicity screens etc. Documented evidence is required.

3.8.1.4. Turnaround times for laboratory results are monitored.

Guideline statement:

Turnaround times from sending specimens by the facility/in-patient unit to receiving results must be determined and monitored by individual facilities. Analysed data required by the M&E framework must be available and provided to the District Programme Coordinator.

3.8.1.5. A laboratory specimen register is kept updated and missing results are followed up.

Guideline statement:

Documented evidence must be provided.

3.9. Community and patient involvement and education

3.9.1. Community outreach programmes are implemented.

Intent of 3.9.1

Mental health service care at the community level must be supported by trained cadres of community health workers (CHW). In Botswana, the concept of community health workers was conceived in the early 1970's with the establishment of the Family Welfare Educators. In the late 2000, the cadre was renamed Health Education Assistants (HEAs).

Designated HEAs within the catchment population of the facility (especially health posts and clinics) should receive basic training in mental health care and provide this care in homes in the communities in which they work. Interventions which have proven effectiveness in reducing mortality should be included in 'enhanced training' for mental health HEAs. Patients, families and the community receive continuous, appropriate high quality information on the importance of mental health care. Regular home visits should be provided by HEAs for identified patients.

Community specific outreach projects and interventions that provide and increase awareness of the programme's facilities and services such as sign boards, detailed locations and contact numbers of facilities, use of mobile technology and integrated communication-transportation systems that function 24/7 should be encouraged by the facility's mental health service team.

The facility's mental health service team and HEAs should cooperate with local health committees and community civic organisations to improve health awareness and implement community interventions that are designed to address the most common dangerous delays that mental health service patients face in the community. Risks such as delays in deciding to seek care for a mental health illness and delays in receiving quality care at health facilities must be addressed.

3.9.1 Criteria

3.9.1.1. Trained Health Education Assistants (HEAs) are available to provide training to patients and the general population in the facility’s catchment population.

Guideline statement:
A current list of HEAs trained in mental health service programme related care who are affiliated with the facility is available.

3.9.1.2. Orientation and training programmes for mental health service HEAs are provided by the facility’s mental health service team.

Guideline statement:
Documented detail of content and training provided is required.

3.9.1.3. The facility’s mental health service team promotes, supports and participates in mental health service related community outreach projects.

Guideline statement:
A current list of projects, including home visit schedules and reports, is documented and available.

3.9.1.4. Printed health education material, in a language common to the catchment population, is distributed in key areas in the community.

Guideline statement:
Materials such as brochures and posters are made available to community frequented centres, organisations and individuals for example schools, churches, crèches, libraries and workplaces.

3.9.2. Patient education protocols and documents (brochures) are available and implemented.

Intent of 3.9.2

Patients, families, caregivers and the general population must be provided with information regarding accessing healthcare services and providers that are available to meet mental health care needs for

routine and emergency care, treatment and services within their community. This includes referrals to social service programmes, therapeutic support services, referral hospitals and healthcare specialists. Written and verbal information on how to contact staff in case of an emergent situation must be provided.

The healthcare professionals providing care must ensure that patients are informed of their rights and responsibilities. Patients and families should be actively involved in decisions about mental health care. Related risks, benefits and alternative treatments must be adequately explained and discussed in a preferred language, considering cultural preferences, in a way that they can understand.

Patients and families must be reminded of the importance of providing all information that is important to care, treatment, and services to healthcare providers.

Information on community resources that are available to meet mental health care needs must be provided.

3.9.2 Criteria

3.9.2.1. Patients, families and caregivers are informed on how to access care, treatment, and services.

Guideline statement:
Compliance will be assessed by means of patient interviews and patient record audits.

3.9.2.2. Patients, families and caregivers are informed about patient rights and responsibilities while receiving care, treatment and services from the mental healthcare service programme.

Guideline statement:
Compliance will be assessed by means of patient interviews and patient record audits.

3.9.2.3. Language and culture appropriate patient educational material for the mental health service programme are available.

Guideline statement:
Material includes free brochures and educational wall posters.

3.9.2.4. Patients, families and caregivers receive information about the staff responsible for the delivery of their care, treatment, and services.

Guideline statement:
Compliance will be assessed by means of patient interviews and patient record audits.

3.9.2.5. Individualised patient education is provided at each interaction and documented in the patient's record.

Guideline statement:
At a minimum, patients, families and caregivers are orientated and educated about:
• Giving oral drugs at home
• Side effects of drugs
• Give instructions on follow-up care
• Give instructions on when to return to the clinic
• Recognition of signs of early relapse.
• How to care for the mentally ill at home
Evidence of compliance will be assessed by means of patient interviews and patient record audits.

3.9.2.6. A system for referrals for grief, bereavement and palliative care services is in place for patients, families and caregivers if indicated.

Guideline statement:
Documented evidence must be available. Compliance will be assessed by means of patient interviews and patient record audits.

3.10. Mental Health Care Service Medical Records and Patient registers

3.10.1. The Botswana Mental Health Care Service Record and all other required legal documents are fully completed and available in the patient's medical record.

3.10.1 Criteria

3.10.1.1. The medical record captures comprehensive information about the mental health care patient.

Guideline statement:

General information for the patient includes at least
• Date and time of each entry
• Identification data on each page
• Medical history: past, current, family history, surgical history, allergies
• Social data
• Consent forms
• Health status assessment
• Physical examination findings
• Plan of care
• Health education
• Medication orders
• Consultative findings
• Diagnostic and laboratory reports, including rapid and point-of care tests
• Medication administration record
• Legible, full names, signatures and designations of the physician or other healthcare professionals
• Mental health care service forms for categorising, treatment and follow-up
• Referral notes
Compliance will be assessed by means of patient record audits.

3.10.1.2. Where there is an EHR system in place, data correlates with the patient–carried medical record.

Guideline statement:

Documented evidence must be available. Compliance will be assessed by means of patient record audits.

3.10.1.3. Measures to ensure security and confidentiality of information are implemented according to Botswana laws and regulations.

Guideline statement:

Guidelines, protocols and policies that provide for identification, security, confidentiality, control, retrieval and preservation of patient care data and information must be available and implemented. In this regard, the content of the Rules of Professional Practice for Nurses (regulations 4-9) must be known and implemented by all nurses. In larger facilities that render mental health care services, a centralised location for medical records that ensures rapid retrieval during all hours should be considered.

3.10.1.4. A current patient register is available.

Guideline statement:

All information on cases seen and discharged or referred and the outcome of treatment are correctly recorded and up to date in the register.

3.11. Assessment and Treatment of Patients

3.11.1. Emergency Triage Assessment and Treatment is performed and recorded in the patient record.

3.11.1 Criteria

3.11.1.1. **CRITICAL** All patients are triaged and categorised upon first contact at the facility and the category is documented.

Guideline statement:

Triage is the process of rapidly examining patients when they first arrive at the facility in order to place them in one of the following categories:
• Those with EMERGENCY SIGNS who require immediate emergency treatment
• Those with PRIORITY SIGNS, indicating that they should be given priority in the queue, so that they can rapidly be assessed and treated without delay
• Those who have no emergency or priority signs and therefore are NON-URGENT cases. These patients can wait their turn in the queue for assessment and treatment.
The majority of mental health patients will be non-urgent and will not require emergency treatment.

3.11.1.2. All staff are trained on emergency signs and priority signs and triage posters are available for easy reference.

Guideline statement:

All categories of staff must be able to do emergency triage and recognise the differences between emergency, priority and non-urgent cases. All patients must be categorised accordingly and treatment must commence as per protocols.
Documented evidence is required.

3.11.1.3. Step-by-step protocols for assessment of each of the emergency and priority signs are developed, implemented, are used for competency assessments.

Guideline statement:

Protocols for rapid assessment of all emergency and priority signs are available and may include pictures and diagrams for ease of reference and training purposes.

3.11.1.4. Step-by-step protocols for treatment of symptoms are developed, implemented and used for competency assessments.

Guideline statement:

Treatment may involve insertion of an oropharyngeal airway, drawing of blood, setting up intravenous infusions, administration of injectable medication, etc. All possible treatment protocols must available, and proof of competence must exist.

3.11.1.5. All assessments, treatment and follow-up care are documented in the medical record in detail.

Guideline statement:

Assessment and treatment may be documented on pre-printed forms that provide the guidelines for the protocol. If written in free-form, all aspects of the protocol must be addressed in the documentation. This would include any Point-of-Care diagnostic testing with results, monitoring and follow-up of the patient while in the unit and referrals to next levels for treatment.

3.11.1.6. Medication for emergency and priority treatment are provided as per approved protocol.

Guideline statement:

The minimum requirement would be medication as per identified protocols for emergency and priority cases.

3.11.1.7. Criteria and processes for referral to a higher level of care must be in place.

Guideline statement:

Mental health care is a primary health function and would often be located outside of facilities that can provide further treatment (secondary or tertiary). Criteria for patients that need to be referred for further treatment, especially in emergency and priority cases, must be available. The process of referral and patient transport must also be addressed in the criteria and protocols.

3.11.2. All patients cared for by the organisation have their healthcare needs identified through an established assessment process.

Intent of 3.11.2

The organisation should define the scope and content of assessments to be performed by each clinical discipline within its scope of practice and applicable laws and regulations as well as those patient populations and special situations for which the initial assessment process is modified.

These findings should be used throughout the care process to evaluate patient progress and understand the need for re-assessment. It is essential that assessments are documented comprehensively and can be easily retrieved from the patient's record.

The organisation should determine the time frame for completing assessments. This may vary in the different settings within the organisation. When an assessment is partially or entirely completed outside
the organisation, the findings should be verified.

3.11.2 Criteria

3.11.2.1. Organisational policies and procedures for assessing patients on arrival at the facility and during ongoing care are implemented.

Guideline statement:

A policy should be available which defines the scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during the assessment of patients. The provision of specifically designed assessment forms for each relevant discipline is considered as evidence of the implementation of such a policy.
The organisational policy must further identify those patient populations and special situations for which the initial assessment process is modified.
Where the required information, according to the patient's presenting complaints/condition is not documented, the score will be adjusted accordingly.
Compliance will be verified during the patient record audit.

3.11.2.2. Only those individuals permitted by applicable laws and regulations or by registration perform the assessments.

Guideline statement:

Compliance will be verified during the patient record audit, which will focus on the legibility of signatures and the identification of designations/qualifications. The absence of notes made by the doctor in the patient record, or other relevant clinical personnel other than nursing personnel will affect the outcome of the audit process.

3.11.2.3. The scope and content of assessment by each discipline is defined.

Guideline statement:

It is accepted that the scope and content of assessment for each discipline is defined if the organisation makes use of standardised formats of clinical assessment forms for specific use by different disciplines. The absence of medical notes or other relevant clinical personnel other than nursing personnel in the patient record will affect the outcome of the audit process.
Compliance will be verified during the patient record audit.

3.11.2.4. Assessments are performed within appropriate time frames and comprehensively documented in the patient's records according to organisational policy.

Guideline statement:

It is important to note that this criterion does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment should be commenced and/or completed.
Compliance will be verified during the patient record audit.

3.11.3. Each patient has an initial assessment which complies with current policies, procedures and guidelines.

Intent of 3.11.3

The initial assessment of a patient is critical for the identification of the needs of the patient and initiation of the care process. Patients' social, cultural and family status are important factors that can influence their response to illness and care. Families can be of considerable help in these areas of assessment and in understanding the patient's wishes and preferences. Economic factors are assessed as part of the social assessment, particularly when the patient and his or her family will be responsible for the cost of all or a portion of the care.

The initial assessment should include the following as a minimum:

a) Health history
b) Physical examination
c) A functional and nutritional assessment where the need is identified
d) Initial psychological assessment.
e) Social, cultural and economic assessment

A functional and nutritional assessment allows for the patient to be referred for specialist care if necessary.

Certain patients may require a modified assessment, e.g. very young patients, the frail or elderly, those terminally ill or in pain, patients suspected of drug and/or alcohol dependency, and victims of abuse and neglect. The assessment process is modified in accordance with local laws and regulations, the culture of the patient population, and involves the family when appropriate.

The outcome from the patient's initial assessment is an understanding of the patient's medical and nursing needs so that care and treatment can begin.

When an assessment is partially or entirely completed outside the organisation, the findings are verified on admission to the organisation and a legible copy is placed in the patient's record. Any significant changes in the patient's condition since the assessment are recorded.

3.11.3 Criteria

3.11.3.1. Each patient has a documented initial assessment which meets organisation policy.

Guideline statement:
Compliance will be verified during the patient record audit

3.11.3.2. The initial assessment includes at least a) – e) in the standard intent above.

Guideline statement:
Compliance will be verified during the patient record audit

3.11.3.3. The initial assessment results in a diagnosis and the formulation of an individualised plan of care for the patient.

Guideline statement:
Compliance will be verified during the patient record audit

3.11.3.4. The organisation identifies patients in pain during the assessment process.

Guideline statement:
Compliance will be verified during the patient record audit

3.11.3.5. Those special/vulnerable patient populations and special situations for which the initial assessment process is modified receive individualised assessments.

Guideline statement:
Compliance will be verified during the patient record audit

3.11.3.6. The findings of assessments performed outside the organisation are verified and documented in the patient's record.

Guideline statement:
Compliance will be verified during the patient record audit

3.11.3.7. Any significant changes in the patient's condition since the assessment performed outside of the organisation are noted in the patient's record.

Guideline statement:
Compliance will be verified during the patient record audit

3.11.4. Healthcare professionals responsible for patient care collaborate to analyse and integrate assessment information.

Intent of 3.11.4

Patients benefit most when the staff responsible for their care work together to analyse the assessment findings and to combine this information into a comprehensive picture of his or her condition. From this collaboration, the patient's needs are identified, the order of their importance is established, and care decisions are made.

3.11.4 Criteria

3.11.4.1. Patient assessment data and information are analysed and integrated by those responsible for the patient's care.

Guideline statement:
This can be achieved by following an appropriate management algorithm and treatment protocols for example those set out by the WHO in their mhGAP programme.

3.11.4.2. Patient needs are prioritised based on assessment results.

Guideline statement:
This can be achieved by following an appropriate management algorithm and treatment protocols for example those set out by the WHO in their mhGAP programme.

3.11.4.3. The patient and/or his or her family participate in the decisions regarding the priority needs to be met.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.5. The care provided to each patient is planned and written in the patient's record.

Intent of 3.11.5

A single, integrated plan is preferable to the entry of a separate care plan by each provider. Collaborative care and treatment team meetings or similar patient discussions are recorded.

Individuals qualified to do so order diagnostic and other procedures. These orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the correct understanding and carrying out of orders.
An organisation decides:

- which orders must be written rather than verbal
- who is permitted to write orders
- where orders are to be located in the patient record.

The method used must respect the confidentiality of patient care information.
When guidelines and other related tools are available and relevant to the patient population and mission of the organisation, there is a process to evaluate and adapt them to the needs and resources of the organisation, and train staff to use them.

3.11.5 Criteria

3.11.5.1. The care for each patient is planned, provided and documented in the patient's record.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.5.2. The patient's response to care and therapeutic interventions is documented in the patient record.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.5.3. Any patient care meetings or other discussions are noted in the patient's record.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.5.4. All procedures and diagnostic tests and reason why they were ordered are performed, and written into the patient's record.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.5.5. Orders are found in a uniform location in patient records.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.5.6. Only those permitted to write orders do so.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.5.7. The results of procedures and diagnostic tests performed are available in the patient's record.

Guideline statement:
This criterion will be scored PC if the results are not initialed by the medical practitioner, the treatment plan does not indicate action taken, or the nursing notes do not indicate that the doctor was informed.
Compliance will be verified during the patient record audit.

3.11.5.8. There are documented reassessments of patients according to organisational policy at intervals appropriate to their condition, plan of care and individual needs.

Guideline statement:
Patients should be reassessed according to clinical need. The nature of these reassessments and the processes to be followed should be defined in organisation policy.
Compliance will be verified during the patient record audit.

3.11.5.9. The plan of care is modified when the patient's needs change.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.6. Risks, benefits, potential complications and care options are discussed with the patient and his or her family or with those who make decisions for the patient.

Intent of 3.11.6

Patients and their families or decision-makers receive adequate information to participate in care decisions. Patients and families are informed as to what tests, procedures and treatments require consent and how they can give consent, for example verbally, by signing a consent form, or through

some other mechanism. Patients and families understand who may, in addition to the patient, give consent. Designated staff are trained to inform patients and to obtain and document patient consent. These staff members clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. Informed consent includes:

- An explanation of the risks and benefits of the planned test/procedure/treatment
- Identification of potential complications
- Consideration of the surgical and non-surgical options available to treat the patient
- The possible alternatives to the proposed test/procedure/treatment.
- The likelihood of successful treatment
- Possible results of non-treatment

The organisation lists all those tests, procedures and treatment which require written, informed consent. Leaders document the processes for the obtaining of informed consent.

The consent process always concludes with the patient signing the consent form, or the documentation of the patient's verbal consent in the patient's record by the individual who provided the information for consent. Documentation includes the statement that the patient acknowledged full understanding of the information. The patient's doctor or other qualified individual provides the necessary information and the name of this person appears on the consent form.

3.11.6 Criteria

3.11.6.1. A detailed consent policy in accordance with Botswana acts and regulations guides consent for out-patient treatment and other procedures.

Guideline statement:
Issues that must be addressed include at least:
• Designated, surrogate guardian decision-maker name and contact information
• Verbal consent procedure in case of emergency
• Refusal of consent
• Consent for treatment
• Consent in the absence of a parent or legal guardian
Documented evidence of implementation must be available. Compliance will be assessed by means of patient record audits and patient interviews.

3.11.6.2. Patients and their families or decision-makers receive adequate, clear, understandable information to enable them to participate in care decisions.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.6.3. There is a written policy guiding the consent for HIV testing which is specific to patients in mental health care.

Guideline statement:
Compliance will be assessed during patient record audits.

3.11.6.4. Patients know the identity of the physician or other practitioners responsible for their care.

Guideline statement:
Name badges should be worn by all personnel members at all times.
Patient interviews will reveal whether personnel introduced themselves to patients.

3.11.6.5. When treatments or procedures are planned, patients know who is authorised to perform the procedure or treatment.

Guideline statement:
The process for obtaining informed consent should include informing the patient of the name of the individual who will be performing the procedure for which consent is being obtained.
Patient interviews will reveal whether personnel introduced themselves to patients.

3.11.6.6. Patients and families participate in care decisions to the extent they choose.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.6.7. **CRITICAL** The information provided is recorded, with the record of the patient having provided written or verbal consent.

Guideline statement:
Compliance will be assessed during patient record audits.

3.11.7. Each patient participates in a structured treatment plan.

Intent of 3.11.7

Each patient has psychotherapeutic interviews with an appropriately qualified person to meet his/her needs.
There is a structured therapeutic environment which allows for group therapy, occupational therapy, or music or art therapy as required by individual patients.

3.11.7 Criteria

3.11.7.1. There is evidence of regular psychotherapeutic interviews as indicated by the programme and individual patient's needs.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.7.2. There is documented participation in a structured therapeutic programme.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.7.3. There is a range of therapeutic activities available, according to the identified needs of the patient.

Guideline statement:
The organisation should document all therapeutic activities available to patients together with relevant information of how to access these activities, e.g. schedules of when the activities are available, contact details of service providers, activities offered by organisations outside of the organisation e.g. local NGO's or other service providers, referral documents, etc.

3.11.7.4. There is documented participation of the patient with his or her family or significant other(s) in group therapy, as appropriate.

Guideline statement:
Compliance will be assessed during patient interviews and patient record audits.

3.11.8. Policies and procedures guide the care of high-risk patients and the provision of high-risk services.

Intent of 3.11.8

Some patients are considered "high-risk" because of their age, condition or the critical nature of their needs. Mental Health Service patients are commonly in this group as they may not speak for themselves, understand the care process or participate in decisions regarding their care.

Policies and procedures are important for staff to understand high-risk patients and services, and to respond in a thorough, competent and uniform manner. The clinical and managerial leaders take responsibility for identifying the patients and services considered high-risk, using a collaborative process to develop policies and procedures and training staff in their implementation.

Policies or procedures identify at least:

a) The care of patients requiring emergency care
b) The management of patients requiring restraint
c) The management of patients who may be a danger to themselves or others
d) Management of the violent patient
e) The care of frail, dependent elderly patients

Clinical guidelines and pathways are frequently helpful and may be incorporated in the process. Monitoring provides the information needed to ensure that the policies and procedures are adequately

implemented and followed for all relevant patients and services.

3.11.8 Criteria

3.11.8.1. Policies and procedures for identified high risk patients and procedures which include at least a) - e) in the standard intent above, are available.

Guideline statement:
The clinical and managerial leaders take responsibility for identifying the patients and services considered high risk, using a collaborative process to develop policies and procedures and training personnel in their implementation. Policies and procedures include at least a) – e) in the standard intent above. Implementation will be verified during the patient record audit.

3.11.8.2. Staff are trained and implement the policies and procedures to guide care.

Guideline statement:
By implication, if the policies are implemented, personnel can be considered to have been trained and this criterion will be scored accordingly. This training could take the form of formal in-service training, introduction at orientation to policies, discussions at departmental meetings, case studies, etc.

3.11.8.3. Patients receive care consistent with the policies and procedures.

Guideline statement:
Where policies and procedures refer to patient care, compliance will be measured against the relevant areas in the patients' records during the record audit process.

3.12. Prevention and control of infection

3.12.1. Procedures for the management of infection prevention and control are implemented and performed as per Botswana policies, protocols and regulations.

3.12.1 Criteria

3.12.1.1. Routine infection prevention and control (IPC) protocols are available and implemented.

Guideline statement:
Policies include IPC protocols for all levels of care in all settings as required by the Botswana National Hospital and Clinic Standards. This includes standard precautions, procedural precautions, surgical precautions, catheter care, personal protective equipment and hazardous waste management. Audits must be performed and results documented and analysed.

3.12.1.2. Guidelines for handwashing in the event of emergency stabilisation procedures must be in place.

Guideline statement:
Before emergency stabilisation procedures, where handwashing may not be possible, for example inserting an IV, resuscitation or administering drugs, it is critical to at least put on and wear gloves in a sterile way, even if hands are not washed. This should be reported and captured on handwashing audits.

3.12.1.3. Adequate supplies of sterile gloves and protective clothing must be available.

Guideline statement:
Adequate supplies of gloves and protective clothing must be available based on the level of facility, staff and volume of infectious patients served.

3.12.1.4. Education for prevention of secondary infections and infection control procedures for home is provided.

Guideline statement:
This includes education about infectious periods of diseases such as measles, wound care for local infections, general hygiene and food hygiene. Documented evidence in the patient record is required. Patient interviews will be conducted.

3.13. Risk management and safety

3.13.1. Procedures for the management of risk and safety are implemented and performed as per Botswana policies, protocols and regulations.

3.13.1 Criteria

3.13.1.1. A mental health service event reporting process and register is available and up to date.
CRITICAL

Guideline statement:
The mental health service programme-specific reportable events are known to all service providers, reported and documented in a facility register.

3.13.1.2. Mental health service programme-specific safety hazards and risks in the environment of care are identified, reported and addressed.

Guideline statement:

Safety risks associated with the mental health service environment of care include the following:
• Safety and security of the patient
• Restraint of a patient
• Identification of patient
• Preventing and controlling infections
• Communication services
• Utility services
• Equipment usage
• Fire safety
• Safety and security of care givers
• Infrastructure risks
Documented evidence is required.

3.13.1.3. Mental health service programme-specific hazards and risks in the provision of care to the patient are identified, reported and monitored.

Guideline statement:

Risks associated with provision of mental health service care include for example:
• Appropriate protocols followed according to classification
• Accurate treatment of identified classifications
• Restraint
• Trips, slips and falls
• Injuries (self-inflicted, attempting to abscond)
• Assaults by other patients.
Documented evidence is required.

3.13.1.4. Mental health service programme-specific hazards and risks in the administration of medication to the patient are identified, reported and monitored.

Guideline statement:

Protocols must be in place for managing risks related to all mental health service and emergency medication activities for at least the following aspects:
• Allergic reactions
• Adverse drug reaction
• Contra-indications
• Dosages
• Emergency resuscitation medication

3.13.1.5. Mental health service programme-specific clinical events resulting from inadequate, unavailable, delayed or sub-standard care to the patient are identified, reported and fully investigated.

Guideline statement:

Clinical adverse events that result in morbidity or mortality to the patient must be reported immediately and fully investigated as per district and national protocol. Included in this criterion is the monitoring of proper triage and categorising of patients.

3.14. Quality improvement and management of information

3.14.1. Programme-specific quality improvement plans and processes for management of information are available and implemented.

3.14.1 Criteria

3.14.1.1. Information management processes meet the programme's internal and external information needs.

Guideline statement:

The facility is provided with/has access to an electronic and/or paper based, integrated standard health information system that enables and assists in collecting and using mental health service specific data. The mental health service team must be able to readily retrieve the data without compromising security and confidentiality.

3.14.1.2. Aggregated data and information is used to monitor and support the mental health service programme's quality improvement activities.

Guideline statement:

The facility's mental health service team uses aggregate data and information to support operations, performance improvement activities and patient care.

3.14.1.3. Monthly and annual data is checked, graphed, displayed and discussed with personnel and the mental health service team and leaders.

Guideline statement:

The programme leaders and facility mental health service team participate in the review, evaluation and revision of its annual performance improvement plan. Documented evidence in the form of reports, minutes of meetings and action plans is required.

3.14.1.4. The facility's improvement opportunities are identified and prioritised based on performance data comparisons against district and national target ranges.

Guideline statement:

Documented evidence in the form of aggregated and analysed data reports, minutes of meetings and action plans is required.

3.14.1.5. The programme plans process and performance improvement activities to encompass multiple disciplines and/or settings from triage, assessment, classification, treatment and referral and/or follow-up stages.

Guideline statement:

This includes mental health service programme-specific quality improvement initiatives unique to the individual facility in addition to the mental health service programme's specific improvement goals.

3.14.1.6. The facility's mental health service team acts on improvement opportunities.

Guideline statement:

Documentation of the interventions taken to improve and evaluate performance on mental health service core measures is required.

3.14.1.7. The facility's Focal Person and programme leaders meet at regular intervals, at least twice a year, to evaluate clinical care practices and protocols and to identify opportunities for performance improvement and progress on implemented improvement projects.

Guideline statement:

Documented evidence in the form of reports, minutes of meetings and action plans is required.