Republic of Botswana

BOTSWANA NATIONAL HEALTH QUALITY STANDARDS FOR CLINICS

4.Management of Information

These forms are designed to be used by both hospital personnel and external surveyors. The following information must be provided after each survey, before submitting the completed survey forms.

1.NAME OF HOSPITAL/CLINIC/FACILITY:_____

2. BASELINE/INTERNAL SURVEY INFORMATION:

Title and name of person who completed this document: _____

Post and position held: _____

Date of survey: _____

3. EXTERNAL SURVEY INFORMATION:

Name of external surveyor: _____

Date of external survey: _____

GUIDE TO COMPLETION OF FORM

N.B. Hospital staff are please to use BLACK ink at all times. The external surveyors are requested to use RED ink at all times.

Please circle the rated compliance with the criterion, e.g. NA (Not applicable), NC (Non-compliant), PC (Partially compliant), C (Compliant).

The default category affected is designated on the form for each criterion as follows:

1. patient and staff safety
2. legality
3. patient care
4. efficiency
5. structure
6. basic management
7. basic process
8. evaluation

The seriousness of the default is designated on the form for each criterion as follows:

1. mild
2. moderate
3. serious
4. very serious

Documents Checked

Surveyor: .....

Surveyor: .....

4.Management of Information

4.1 Information Planning

4.1.1 Standard

The health facility meets the information needs of all those who provide clinical care, those who manage the service and those outside the health facility who require data and information from the health facility.

Standard Intent: Information is generated and used during patient care and for safely and effectively managing an organisation. The ability to capture and provide information requires effective planning. Planning incorporates input from a variety of sources:

- the care providers
- the organisation's managers and leaders, and
- those outside the organisation who need or require data or information about the organisation's operational and care processes.

The most urgent information needs of those sources influence the organisation's information management strategies and its ability to implement those strategies. The strategies are appropriate for the organisation's size, complexity of services, availability of trained personnel and other human and technical resources. The plan is comprehensive and includes all the departments and services of the organisation**.**

There is a system integrating administrative data such as the number of patients per department, enrolment data, utilisation, bed occupancy rate where applicable and human resources data supported by IT or paper-based administration systems. The collection of data is based on the systematically investigated need for information within the organisation.

	Criterion	Comments Recommendations
Criterion 4.1.1.1 Critical: .. Catg: Basic Management + Efficiency **Compliance** **NA NC PC C** Default Severity for NC or PC = 3 Serious	The health facility uses a health information system that facilitates the collection and utilisation of data.	
Criterion 4.1.1.2 Critical: .. Catg: Basic Management + Efficiency **Compliance** **NA NC PC C** Default Severity for NC or PC = 3 Serious	The information system includes data required to measure the objectives set for each programme provided by the health facility.	

Criterion 4.1.1.3 Critical: .. Catg: Basic Management + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The requirements for the collection, collation, validation and distribution of data are clearly defined in the system.	
Criterion 4.1.1.4 Critical: .. Catg: Basic Management + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The system identifies those permitted access to each category of data and information.	
Criterion 4.1.1.5 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The health facility collects data in a timely and efficient manner.	
Criterion 4.1.1.6 Critical: .. Catg: Basic Management + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Systems are in place for the storage and retrieval of patient information.	

4.2 Analysis of Data

4.2.1 Standard

There is a relevant system for the analysis of data.

Standard Intent: To reach conclusions and make decisions, data must be aggregated, analysed and transformed into useful information. Data analysis involves individuals with an understanding of information management and skills in data aggregation methods, and in the use of various statistical tools. Data analysis involves the individuals responsible for the process or outcome being measured. These individuals may be clinical, managerial or a combination. Thus, data analysis provides the continuous feedback of quality management information to help those individuals make decisions and continuously improve clinical and managerial processes.

The health facility determines how often data is aggregated and analysed. The frequency depends on the activity or area being measured, the frequency of measurement and the health facility's priorities. For example, clinic data may be analysed weekly to meet national regulations, but patient fall data may be analysed monthly if falls are infrequent.Thus aggregation of data at points in time enables the health facility to judge a particular process's stability or a particular outcome's predictability in relation to expectations.

When the health facility detects or suspects an undesirable change from what is expected, it initiates intense analysis to determine where best to focus improvement. In particular, intense analysis is initiated when levels, patterns or trends vary significantly or undesirably from:

- what is expected
- those of other health facilities, or
- recognised standards.

Certain events related to specific processes always result in intense analysis to understand the cause and prevent recurrence. When appropriate to the health facility's services, these events include:

- confirmed transfusion reactions
- significant adverse drug reactions
- significant medication errors
- significant discrepancies between preoperative and postoperative diagnosis, and
- significant adverse anaesthetic events.

Each health facility establishes which events are significant and the process for their intense analysis. When undesirable events can be prevented, the health facility works to carry out preventive changes.

The goal of data analysis is to be able to compare a health facility in four ways:

- with itself over time, such as month to month, or one year to the next
- with other similar health facilities, such as through reference databases
- with standards, such as those set by accrediting and professional bodies, or those set by laws or regulations, and
- with desirable practices identified in the literature, such as practice guidelines.

These comparisons help the health facility to understand the source and nature of undesirable change and help to focus improvement efforts.

Understanding statistical techniques is helpful in data analysis, especially in interpreting variation and in deciding where improvement is needed. Run charts, control charts, histograms and Pareto charts are examples of statistical tools that are useful when seeking to understand trends and variations in healthcare.

Criterion	Comments
	Recommendations

4.Management of Information

Criterion 4.2.1.1 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Data is aggregated, analysed and transformed into useful information.	
Criterion 4.2.1.2 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The frequency of data analysis is appropriate to the process under study.	
Criterion 4.2.1.3 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The frequency of data analysis meets the requirements of the health facility.	
Criterion 4.2.1.4 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Intense analysis of data takes place when there are significant adverse levels, patterns or trends, as established by the health facility.	
Criterion 4.2.1.5 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Statistical tools and techniques are used in the analysis process when suitable.	

4.3 Information Usage

4.3.1 Standard

Health statistics are collected as required and reported in a timely manner to responsible officers.

	Criterion	Comments Recommendations
Criterion 4.3.1.1 Critical: .. Catg: Basic Process + Legality **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	The health facility contributes to external reference databases when required by laws or regulations.	
Criterion 4.3.1.2 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The health facility manager or delegated person checks data leaving the facility for completeness, correctness and consistency.	
Criterion 4.3.1.3 Critical: b Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	The performance of the facility on identified priority indicators forms part of the discussions at regular staff meetings.	
Criterion 4.3.1.4 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The performance of the facility on identified priority indicators forms part of the discussions at meetings with community representatives.	

Criterion 4.3.1.5 Critical: .. Catg: Basic Management + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Targets for identified priority indicators are known to the facility manager and the information coordinator for the facility.	
Criterion 4.3.1.6 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The facility uses information from external data sources for benchmarking.	

4.3.2 Standard

There is a programme for using information to improve practice.

	Criterion	Comments Recommendations
Criterion 4.3.2.1 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Data relating to the meeting of objectives for each programme is made available to the health facility personnel at least quarterly.	
Criterion 4.3.2.2 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Data is analysed and used to provide relevant information for improving the clinical service.	
Criterion 4.3.2.3 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	There is a regular scheduled meeting, at least quarterly, to review institutional mortalities and morbidities.	

4.4 Patient Health Records

4.4.1 Standard

The organisation has defined the type and content of patient records.

	Criterion	Comments Recommendations
Criterion 4.4.1.1 Critical: .. Catg: Basic Management + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	There are written policies and procedures relating to the type of patient record used, e.g. carry cards or other health records.	
Criterion 4.4.1.2 Critical: .. Catg: Basic Management + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Policies specify the records or registers relating to the visits of each patient to be kept by the health facility.	
Criterion 4.4.1.3 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 2 Moderate	Standardised diagnostic and procedure codes are used, if required.	
Criterion 4.4.1.4 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 2 Moderate	Symbols and definitions are standardised.	

Criterion 4.4.1.5 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Each patient has a record which is provided with a unique number.	

4.4.2 Standard

Patient records contain the required information.

Standard Intent: There is a clinical record for each patient and it contains the following documented information:
This information promotes continuity of care among healthcare providers.

	Criterion	Comments Recommendations
Criterion 4.4.2.1 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	The patients' records are up to date to ensure the transfer of the latest information between care providers.	
Criterion 4.4.2.2 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	The complete patient record containing notes by medical, nursing and other health professionals should be readily available to healthcare providers.	
Criterion 4.4.2.3 Critical: .. Catg: Basic Management + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	There is a standardised format for recording patient assessment and treatment.	

Criterion 4.4.2.4 Critical: .. Catg: Basic Process + Legality **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	The signature and designation of the signatory can be identified for each patient record entry.	
Criterion 4.4.2.5 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The date of each patient record entry can be identified.	
Criterion 4.4.2.6 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	The plan of care for each patient is noted in the patient record.	
Criterion 4.4.2.7 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Nursing care plans are updated after each shift.	
Criterion 4.4.2.8 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	All procedures and diagnostic tests requested are noted in the patient's record.	

Criterion 4.4.2.9 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	There is evidence of review of the results of procedures and diagnostic tests performed.	
Criterion 4.4.2.10 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Re-assessments are documented in the patient's record.	
Criterion 4.4.2.11 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Medications prescribed and administered are recorded for each patient.	
Criterion 4.4.2.12 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Adverse drug reactions are noted in the patient's record.	
Criterion 4.4.2.13 Critical: b Catg: Basic Process + Pat & Staff Safety **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Medication errors are reported through a process and within a time frame defined by the organisation.	

Criterion 4.4.2.14 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Patient and family education provided is noted in the patient's record.	
Criterion 4.4.2.15 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	Follow-up instructions are recorded in the patient's record.	
Criterion 4.4.2.16 Critical: .. Catg: Evaluation + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	A document audit process regularly reviews patient records.	
Criterion 4.4.2.17 Critical: .. Catg: Evaluation + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Clinical information is used in clinical monitoring as part of a structured clinical audit.	

4.4.3 Standard

A discharge summary is written for each inpatient and made available in the patient's record.

Standard Intent: The discharge summary is one of the most important documents to ensure continuity of care and facilitate correct management at subsequent visits. Information provided by the organisation may include when to resume daily activities, preventive practices relevant to the patient's condition and, when appropriate, information on coping with disease or disability.

The summary contains at least:
a) the reason for admission b) the diagnosis of main and significant illnesses c) the results of investigations that will influence further management d) all procedures performed e) the patient's condition at discharge, and f) discharge medications and follow-up instructions.

	Criterion	Comments Recommendations
Criterion 4.4.3.1 Critical: .. Catg: Basic Process + Patient Care **Compliance** **NA NC PC C** Default Severity for NC or PC = 4 Very Serious	A discharge summary, which includes items a) to f) in the intent statement, is written by the medical practitioner at the discharge of each patient.	
Criterion 4.4.3.2 Critical: .. Catg: Basic Process + Efficiency **Compliance** **NA NC PC C** Default Severity for NC or PC = 3 Serious	Each record contains a copy of the discharge summary.	

4.5 Health Record Maintenance

4.5.1 Standard

There is an established health record storage system that ensures confidentiality and safety.

Standard Intent: Health record management must be implemented by a person with suitable training and experience. The manager controls the safe storage and retrieval of files. Files must be readily available each time the patient visits a healthcare professional and therefore must be filed in such a way that they are easily identified. Policies and procedures as well as managerial supervision ensure the safety and confidentiality of files. Loss of information may be through electronic failure, fire, flood or theft. The organisation develops and implements a policy that guides the retention of patient records and other data and information. Patient records and other data and information are retained for sufficient periods to comply with law and regulation and support patient care, the management of the organisation, legal documentation, research and education. The retention policy is consistent with the confidentiality and security of such information. When the retention period is complete, patient records and other data and information are destroyed appropriately.

Facilities make more and more use of electronic systems, requiring these standards and criteria to be assessed appropriately in such instances. These electronic systems vary greatly in their application and can range from a simple spreadsheet to register all patient admissions/folders to very sophisticated systems where the entire patient record is kept electronically.

Often organisations do not have a single, central location from where records are managed and it is important to apply the standards and criteria to ALL areas where patient records are being handled, stored or archived. All these areas (that are under the control/management of the organisation) need to be visited during the survey, even if located off-site (e.g. across the street, on an adjacent plot or within reasonable travelling distance). This assessment does not include warehouses of private companies to whom the archiving of records has been contracted out, as the service agreement/contract will have to make provision for monitoring compliance with specifications.

	Criterion	Comments Recommendations
Criterion 4.5.1.1 Critical: .. Catg: Basic Management + Efficiency **Compliance** **NA NC PC C** Default Severity for NC or PC = 3 Serious	A designated individual is responsible for the storage, maintenance and retrieval of health records.	
Criterion 4.5.1.2 Critical: .. Catg: Basic Process + Efficiency **Compliance** **NA NC PC C** Default Severity for NC or PC = 3 Serious	The health facility manager ensures that policies and procedures are implemented to guide the personnel.	

Criterion 4.5.1.3 Critical: b Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Policies and procedures relate to the safeguarding of information in the record against loss, damage, breach of confidentiality or use by unauthorised persons.	
Criterion 4.5.1.4 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 3 Serious	There is a system which allows for the rapid retrieval and distribution of health records.	
Criterion 4.5.1.5 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 2 Moderate	The filing system allows for incorrectly filed records to be easily identified (e.g. through colour coding of the records).	
Criterion 4.5.1.6 Critical: .. Catg: Basic Management + Legality **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	The health facility has a policy on the retention of patient records and other data and information.	
Criterion 4.5.1.7 Critical: .. Catg: Basic Process + Patient Care **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	The retention process provides the necessary confidentiality and security.	

Criterion 4.5.1.8 Critical: .. Catg: Basic Process + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Policies and procedures are developed for health record destruction, specifying the criteria for selection and the method of destruction.	
Criterion 4.5.1.9 Critical: .. Catg: Basic Management + Efficiency **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	There is provision for authorised access to patient records at all times.	
Criterion 4.5.1.10 Critical: .. Catg: Basic Management + Physical Struct **Compliance** NA NC PC C Default Severity for NC or PC = 4 Very Serious	Storage space for health records is sufficient and secure against unauthorised entry.	