Republic of Botswana

National Health Quality Standards

Standards & Guidelines for Emergency Medical Services

Improving Quality & Safety of Health Services

National Health Quality Standards

Standards & Guidelines
For Emergency Medical Services

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ABBREVIATIONS

ACLS	Advanced Cardiac Life Support
AEA	Ambulance Emergency Assistant.
ALS	Advanced Life Support
ATLS	Advanced Trauma Life Support
BAA	Basic Ambulance Attendant (a.k.a. BAA)
BAC	Basic Ambulance Certificate (a.k.a. BAC)
BCA	Biological and Chemical Agents
BHPC	Botswana Health Professions Council
BLS	Basic Life Support
CDO	Chief Divisional Officer
COHSASA	Council for Health Service Accreditation of Southern Africa
DO	Divisional Officer
ECP	Emergency Care Practitioner
ECT	Emergency Care Technician
EMD	Emergency Medical Dispatch(er)
EMS	Emergency Medical Services
ILS	Intermediate Life Support
ISQua	International Society for Quality in Health Care
ITLS	International Trauma Life Support
JCI	Joint Commission International
MD	Medical Director
NALS	Neonatal Advanced Life Support (a.k.a. NALS)
NRP	Neonatal Resuscitation Program (a.k.a. NRP)
PALS	Paediatric Advanced Life Support
PHTLS	Pre-Hospital Trauma Life Support
PTV	Patient Transport Vehicle
SMO	Supervising Medical Officer

Foreword

The Government of Botswana through the Ministry of Health has since independence managed to build healthcare facilities of different capacities delivering health services at different levels of care. The adoption of the Primary Healthcare strategy has critically influenced the development of public health facilities to be in areas within reach of every citizen. In addition over the years the private health sector has also grown significantly. This has always been a good development pertaining to access to healthcare by the people of this country.

Notwithstanding the above, there have been some major challenges faced by our health system, one which is provision of quality and safe health services. People are no longer complaining of lack of hospitals and clinics but rather of the quality and safety of service they receive. The National Health Quality Standards represent a new approach in the way we provide healthcare and are aimed at propelling us to greater heights in meeting the needs and expectations of our patients and the public at large. They set out basic requirements that will promote delivery of services based on shared values, and also establish the basis for continuous improvement of the quality and safety of the patient care. The standards will not only provide a framework for self assessment and for external review and investigation, but would also enhance the reputation and credibility of our healthcare system. Their implementation framework provides an execution strategy or road map to realize this.

These National Health Quality Standards have been designed in such a way that they can be implemented in all types of health services or settings. They provide the foundation which is applicable to the full spectrum of patient care for the various levels of care in an organization as a whole and to specific areas as appropriate.

I urge all providers to use them to strive to continuously improve the quality and safety of care. May I kindly underscore that successful implementation of the standards requires all health sectors whether in Government and private sector to take account of the quality and safety of all their services. They should conduct self-assessments against the standards and manage their performance. It is envisaged that all healthcare service providers will be subjected to compliance with the standards once the legislation is put in place. I therefore urge all providers to adopt the standards in advance of the proposed legislation. Progress by health sectors to achieve compliance against these standards will be assessed through independent inspections and audits.

I am confident that their implementation will build on the improvements achieved this far and will serve as a catalyst for a change to a culture of continuous improvement that puts the patients at the forefront so that we are able to provide the right care for the right person at the right time, the first time.

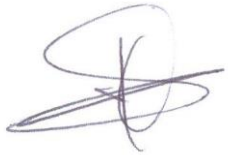
Rev. Dr. John G.N. Seakgosing
Minister of Health

Acknowledgements

The National Health Quality Standards are a product of various stakeholders drawn from different disciplines from both Government and private sector and other interested stakeholders. The Ministry of Health acknowledges enormous support from the Council for Health Service Accreditation of Southern Africa (COHSASA) who through their expertise and advice have made the development of the National Health Quality Standards a reality.

Our sincere thanks to the general public and various stakeholders with vested interest in healthcare for their valuable inputs and comments; and Medical Rescue International Botswana Limited (MRI Botswana) for allowing us to use their facility as a pilot test site for the emergency medical services standards.

Lastly, let me be mindful of the fact that health is dynamic and assure you that the Government is committed to ensure that these standards remain relevant and the Ministry will be thankful to all stakeholders to be involved in their continuous monitoring and future reviews.



Dr. K. Seipone
Director Health Services

DEFINITION OF TERMS USED

Acceptability	Acknowledgement that the reasonable expectations of the patient, funders and the community have been satisfied.
Accessibility	Means that access to healthcare services is unrestricted by geographic, economic, social, cultural, organisational or linguistic barriers.
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Accreditation	A determination by an accrediting body that an eligible organisation is in compliance with applicable predetermined standards. (See also certification, licensure.)
Adverse event	An adverse event may be defined as any event or circumstance that leads to unintended or unexpected physical or psychological injury, disease, suffering, disability or death not related to the natural cause of the patient's illness, underlying condition or treatment.
Advocacy	Representation of individuals who cannot act on their own behalf and/or promoting individual rights and access to the resources that will allow them to fulfil their responsibilities.
Ambulance	A patient carrying vehicle equipped to facilitate emergency transport and care of ill or injured patients. (see PTV)
Appraisal system	The evaluation of the performance of individuals or groups by colleagues using established criteria.
Appropriateness	The extent to which a particular procedure, treatment, test or service is effective, clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to the client's needs.
Assessment	Process by which the characteristics and needs of clients, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action.
Audit	1. Systematic inspection of records or accounts by an external party to verify their accuracy and completeness. 2. Periodic in-depth review of key aspects of the organisation's operations. An audit provides management with timely information about specific topics and/or the cost-effectiveness of operations, addressing both quality and resource management issues. 3. In performance measurement, regular systematic,

	focused inspections by an external party of organisation records and data management processes to ensure the accuracy and completeness of performance data. 4. See also clinical audit.
Benchmarking	A method of improving processes by studying the processes of organisations that have achieved outstanding results and adapting these processes to fit the particular needs and capabilities of the healthcare facility concerned.
Biologicals	Medicines made from living organisms and their products including, for example, serums, vaccines, antigens and antitoxins.
Biohazard	Biohazards are infectious agents or hazardous biological materials that present a risk or potential risk to the health of humans, animals or the environment. The risk can be direct (through infection) or indirect (through damage to the environment). Biohazardous materials include certain types of recombinant DNA: organisms and viruses infectious to humans, animals or plants (e.g. parasites, viruses, bacteria, fungi, prions, rickettsia), and biologically active agents (i.e. toxins, allergens, venoms) that may cause disease in other living organisms or cause significant impact to the environment or community. Biological materials not generally considered to be biohazardous may be designated as biohazardous materials by regulations and guidelines.
Business plan	A plan of how to achieve the mission of the facility. The plan includes financial, personnel and other sub-plans, as well as service development and a quality strategy.
Cardiopulmonary resuscitation (CPR)	The administration of artificial heart and/or lung action in the event of cardiac and/or respiratory arrest. The two major components of cardiopulmonary resuscitation are artificial ventilation and closed-chest cardiac massage.
Carer	Anyone who regularly and, in an unpaid capacity, helps a relative or friend with domestic, physical or personal care required by virtue of illness or disability.
Certification	The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual, institution or programme as meeting predetermined requirements, such as standards. Certification differs from accreditation in that certification can be applied to individuals, e.g. a medical specialist, whereas accreditation is applied only to institutions or programmes, e.g. a clinic/health centre or a training programme. Certification programmes may be non-governmental or governmental and do not exclude the uncertified from practice, as do licensure programmes. While licensing is meant to establish the minimum competence required to protect public health, safety and

	welfare, certification enables the public to identify those practitioners who have met a standard of training and experience that is set above the level required for licensure.
Clinic	1. A defined healthcare session in a healthcare setting. 2. A defined healthcare setting.
Clinical audit	A clinically led initiative that seeks to improve the quality and outcome of patient care through structured peer review, in terms of which clinical personnel examine their practices and results against agreed standards and modify their practice where indicated.
Clinical personnel	All healthcare workers who are registered/enrolled with a professional body, and who are involved in the care of clients/patients in a particular setting. (See also health professionals.)
Clinical practice guideline	A generally accepted principle for patient management based on the most current scientific findings, clinical expertise and community standards of practice.
Clinical practice pathway	The optimal sequence and timing of interventions by physicians, nurses and other disciplines for a particular diagnosis or procedure, designed to minimise delays and resource utilisation and to maximise the quality of care. Clinical pathways differ from practice guidelines, protocols and algorithms as they are used by a multidisciplinary team and focus on quality and coordination of care.
Clinician	Refers to a person registered as a medical doctor.
Clinical privileges	Authorisation granted by the governing body to clinical personnel to provide specific patient care services in the organisation within defined limits, based on an individual practitioner's registration, education, training, experience, competence, health status and judgement. (See also privileging.)
Clinical waste	Clinical waste is waste arising from medical, dental or veterinary practice or research, which has the potential to transmit infection. Other hazardous waste, such as chemical or radioactive, may be included in clinical waste, as well as waste such as human tissues, which requires special disposal for aesthetic reasons.
Community	A collection of individuals, families, groups and organisations that interact with one another, cooperate in common activities and solve mutual concerns, usually in a geographic locality or environment.
Compliance	To act in accordance with predetermined requirements, such as standards.

Compliance survey	An external evaluation of an organisation to assess its level of compliance with standards and to make determinations regarding its compliance status. The survey includes evaluation of documentation provided by personnel as evidence of compliance, verbal information concerning the implementation of standards, or examples of their implementation that will enable a determination of compliance to be made, and on-site observations by surveyors.
Confidentiality	The assurance of limits on the use and dissemination of information collected from individuals.
Contaminated blood supplies	1. Any blood supply that was issued to a patient after cross matching, but was not used. 2. Any blood that was not transfused and is left in the bag. 3. The empty bags after a blood transfusion.
Continuity	The provision of coordinated services within and across programmes and organisations, and during the transition between levels of services, across the continuum, over time, without interruption, cessation or duplication of diagnosis or treatment.
Continuum	The cycle of treatment and care incorporating access, entry, assessment, care planning, implementation of treatment and care, evaluation and community management.
Continuing education	1. Activities designed to extend knowledge to prepare for specialisation and career advancement and to facilitate personal development. 2. Education beyond initial professional preparation that is relevant to the type of client service delivered by the organisation that provides current knowledge relevant to the individual's field of practice, and that is related to findings from quality improvement activities.
Contract administration	Written agreements and the administration thereof between the purchaser of the service (the healthcare facility) and the provider of the service (the external company).
Contracted service	A service that is obtained by the organisation through a contract with an agency or business. The contracted service is monitored and coordinated by the organisation's staff and complies with national regulations and organisational policies.
Credentialing	The process of obtaining and reviewing the clinical training, experience, certification and registration of a healthcare professional to ensure that competence is maintained and

	consistent with privileges.
Criterion	A descriptive statement that is measurable and that reflects the intent of a standard in terms of performance, behaviour, circumstances or clinical status. A number of criteria may be developed for each standard.
Data	Unorganised facts from which information can be generated.
(a)Longitudinal data	Implies that it is for a given time span.
(b)Comparative data	When a data set is compared with like data sets or with a given time, usually of the previous month or year.
Data retention	Guidelines on how long an organisation should keep information on various media.
Delegation	Act or function for which the responsibility has been assigned to a particular person or group. The ultimate accountability for the act remains with the original delegating person or group.
Discharge note	The discharge note provides the patient and the patient's carers with written follow-up instructions, including medication, any specific dietary and medical orders and when to return for follow-up treatment, or where the patient must go to obtain further treatment.
Effectiveness	Successfully achieving or attaining results (outcomes), goals or objectives.
Efficiency	Refers to how well resources (inputs) are brought together to achieve results (outcomes) with minimal expenditure.
Element, generic	An organisational system within a service element that must achieve and maintain the stated standards and criteria in order for the service element to function optimally.
Element, service	Organisational unit of the clinic/health centre or staff with a director, manager or other designated person in charge. May be a professional service, such as nursing or surgery, a professional support service, e.g. radiology or physiotherapy, a general support system such as administration or health record system, a committee to guide aspects of the service, e.g. health and safety, or a community health service.
Ethics	Standards of conduct that is morally correct.
Evaluation	1. The process of determining the extent to which goals and objectives have been achieved. Actual performance or quality is compared with standards in order to provide a feedback mechanism that will facilitate continuing improvement.

Facility	The health centre, general practice or any other site providing a health service.
Function	A goal directed, interrelated series of processes, such as patient assessment, patient care and improving the organisation of care.
Governance	The function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its mission.
Governing body	Individuals, group or agency with ultimate authority and accountability for the overall strategic directions and modes of operation of the organisation, also known as the council, board, etc.
Guidelines	Principles guiding or directing action.
Health professionals	Medical, nursing or allied health professional personnel who provide clinical treatment and care to clients, having membership of the appropriate professional body and, where required, having completed and maintained registration or certification from a statutory authority. (See also clinical personnel).
Health promotion	Process that enables people to increase control over and to improve their health (World Health Organisation 1986).
Health record	Compilation of pertinent facts of a patient's life and health history, including past and present needs and interventions, written by team members contributing to the care and treatment of the patient.
Health summary	A 'health summary' is written by the medical practitioner assisted by the nurse in charge of the medical record. It can be read once the patient has been discharged and revisits the same clinic/health centre. The health summary will quickly and accurately inform the staff at the clinic/health centre of the condition and treatment the patient received at the previous visit.
High-risk	Refers to aspects of service delivery which, if incorrect, will place clients at risk or deprive them of substantial benefit.
High-volume	Refers to aspects of service delivery that occur frequently or affect large numbers of clients.
Human resource planning	Process designed to ensure that the personnel needs of the organisation will be constantly and appropriately met. Such planning is accomplished through the analysis of internal factors such as current and expected skill needs, vacancies, service expansions and reductions, and factors in the external environment such as the labour market.

Implementation	The delivery of planned healthcare.
Integrity of data	Relates to the completeness and accuracy of a set of data required to fulfil a particular information need. This data is protected from unauthorised additions, alterations or deletions.
Incident plan, external	A plan that defines the role of the clinic/health centre in the event of a major national or local disaster that may affect the health of many people. The plan is developed in participation with the relevant local authority, police, civil defence, fire brigade and ambulance teams.
Incident plan, internal	A plan that provides details of preparation for action in the event of a disaster within the clinic/health centre that affects the health or safety of patients and staff, such as fire, bomb threats, explosions or loss of vital services.
Incidents	Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on clients, groups, staff or the organisation.
Indicator	1. A measure used to determine, over time, performance of functions, systems or processes. 2. A statistical value that provides an indication of the condition or direction, over time, or performance of a defined process, or achievement of a defined outcome. 3. The measurement of a specific activity that is being carried out in a healthcare setting, e.g. weight for age is a measurement of a child's nutritional status.
Induction programme	Learning activities designed to enable newly appointed staff to function effectively in a new position.
Information	Data that is organised, interpreted and used. Information may be in written, audio, video or photographic form.
Information management	Planning, organising and controlling data. Information management is an organisation-wide function that includes clinical, financial and administrative databases. The management of information applies to computer-based and manual systems.
Informed consent	Informed consent is a process whereby a patient is provided with the necessary information/education to enable him/her to evaluate a procedure with due consideration of all the relevant facts. This will enable the patient to make an appropriate decision when determining whether to consent to or refuse the proposed treatment.

	The patient or the guardian should be informed about the patient's condition in as much detail as possible and in simple, non-medical language. The proposed service should be described and, if an invasive procedure is envisaged, it should be clearly explained. Facility staff must confirm that the patient or guardian has understood every detail. Should the procedure or treatment have risks or side-effects, these should be described, making sure they are understood. In the same way, the benefits and possible outcomes should be discussed. Alternative treatments should be offered and discussed. If the patient/guardian should refuse the procedure/treatment, the consequences of such a decision should be made clear and, if a second opinion is sought, the patient/guardian should be apprised of the consequences of the delay and be assisted in obtaining a second opinion.
Information system	Network of steps to collect and transform data into information that supports decision making.
In-service training	Organised education designed to enhance the skills of the organisation's staff members or teach them new skills relevant to their responsibilities and disciplines. Usually provided in-house i.e. at the place of employment.
Job description	Details of accountability, responsibility, formal lines of communication, principal duties and entitlements. It is a guide for an individual in a specific position within an organisation.
Leader	A person providing direction, guidance, regulation or control. A person followed by others.
Leadership	The ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people, and motivating and inspiring people to overcome obstacles.
Licensing	The process whereby a governmental authority grants a healthcare organisation permission to operate following an on-site inspection to determine whether minimum health and safety standards have been met.
Manager	An individual who is in charge of a certain group of tasks, or a certain section of an organisation. A manager often has a staff of people who report to him or her. Synonyms: director, executive, head, supervisor, overseer, foreman.
Management	Setting targets or goals for the future through planning and budgeting, establishing processes for achieving targets and allocating resources to accomplish plans. Ensuring that

	plans are achieved by the organisation, staffing, controlling and problem solving.
Mechanism	The mode of operation of a process or a system of mutually adapted parts working together.
Medical practitioner	Registered medical practitioners are medical doctors with a medical degree registered as medical practitioners in the country they practice in by the statutory registration authority of that country. A general practitioner (GP) is a medical practitioner who treats acute and chronic illnesses and provides preventive care and health education for all ages and all sexes. They have particular skills in treating people with multiple health issues and comorbidities. The word physician is largely reserved for certain other types of medical specialists, notably in internal medicine. A physician is a healthcare provider who practices the profession of medicine, which is concerned with promoting, maintaining or restoring human health through the study, diagnosis, and treatment of disease, injury and other physical and mental impairments. They may focus their practice on certain disease categories, types of patients or methods of treatment – known as specialist medical practitioners Both the role of the physician and the meaning of the word itself vary around the world, including a wide variety of qualifications and degrees.
Mission statement	A statement that captures an organisation's purpose, customer orientation and business philosophy.
Monitoring	A process of recording observations of some form of activity.
Monitoring and evaluation	A process designed to help organisations effectively use their quality assessment and improvement resources by focusing on high-priority, quality-of-care issues. The process includes: identifying the most important aspects of the care that the organisation (or department/service) provides by using indicators to systematically monitor these aspects of care, evaluating the care at least when thresholds are approached or reached to identify opportunities for improvement or problems, taking action(s) to improve care or solve problems, evaluating the effectiveness of those actions and communicating findings through established channels.
Multidisciplinary	The combination of several disciplines working towards a common goal.
Multidisciplinary team	A number of people of several disciplines with complementary skills whose functions are interdependent. They work together for a common purpose or result

	(outcome) on a short-term or permanent basis. Examples include project, problem-solving, quality improvement and self-managed teams. For instance, the management team and quality improvement steering committees are multidisciplinary teams.
Objective	A target that must be reached if the organisation is to achieve its goals. It is the translation of the goals into specific, concrete terms against which results can be measured.
Organisation	Comprises all sites/locations under the governance of and accountable to the governing body/owners.
Organisational chart	A graphic representation of responsibility, relationships and formal lines of communication within the facility.
Orientation programme	1. Activities designed to introduce new personnel to the work environment. 2. The process by which an individual becomes familiar with all aspects of the work environment and responsibilities, or the process by which individuals, families and/or communities become familiar with the services and programmes offered by the organisation.
Outcome	Refers to the results of the healthcare provided, expressed in terms of the patient's health status, or physical or social function.
Patient Transport Vehicle	PTVs are designated, non-emergency patient transport vehicles. They are not equipped to the same life support levels as ambulances and are primarily used for elective patient shuttle.
Peer review	The systematic, critical analysis of care, including the procedures used, treatment provided, the use of resources and the resulting outcome and quality of life for the patient, with a view to improving the quality of patient care by a group of persons of the same professional background.
Performance appraisal	The continuous process by which a manager and a staff member review the staff member's performance, set performance goals, and evaluate progress towards these goals.
Performance measure	A quantitative tool or instrument that provides an indication of an organisation's performance regarding a specified process or outcome.
Planning	The determination of priorities, expected outcomes and health interventions.

Planning, operational	Determining ways in which goals and objectives can be achieved.
Planning, project	The art of directing and coordinating human and material resources throughout the life of a project by using modern management techniques in order to achieve predetermined objectives of scope, quality, time and cost, and participant satisfaction.
Planning, strategic	Determining an organisation's mission and determining appropriate goals and objectives to implement the mission.
Policy	Written statements that act as guidelines and reflect the position and values of the organisation on a given subject.
Practice	Partners in a professional practice, employed personnel and their patients/ clients.
Primary Healthcare	The first level of contact of individuals, the family and community with the public health system, bringing healthcare as close as possible to where people live and work. Primary healthcare includes health education, promotion of proper nutrition, maternal and child healthcare (including family planning), immunisation against the major infectious diseases, appropriate treatment of common diseases and injuries, and the provision of essential drugs.
Privileging	Delineation, for each member of the clinical staff, of the specific surgical or diagnostic procedures that may be performed and the types of illness that may be managed independently or under supervision.
Procedure	A mode of action. A procedure outlines the detailed steps required to implement a policy.
Process	A sequence of steps through which inputs (from healthcare facilities) are converted into outputs (for patients).
Professional registration	Registration in terms of current legislation pertaining to the profession concerned (e.g. the Health Professions Act no 56 of 1974 and its associated regulations).
Professional staff	Staff who have a college or university level of education, and/or who may require licensure, registration or certification from a national authority in order to practice, and/or staff who exercise independent judgment in decisions affecting the service delivered to clients.
Professional team	A number of healthcare professionals whose functions are interdependent. They work together for the care and treatment of a specific patient or group of patients.

Protocol	A formal statement. May include written policies, procedures or guidelines.
Quality	Degree of excellence. The extent to which an organisation meets clients' needs and exceeds their expectations.
Quality activities	Activities that measure performance identify opportunities for improvement in the delivery of services and include action and follow-up.
Quality control	The monitoring of output to check if it conforms to specifications or requirements and action taken to rectify the output. It ensures safety, transfer of accurate information, accuracy of procedures and reproducibility.
Quality improvement	The actions undertaken throughout the organisation to increase the effectiveness and efficiency of activities and processes, in order to bring added benefits to both the organisation and its customers.
Quality improvement programme	1. A planned, systematic use of selected evaluation tools designed to measure and assess the structure, process and/or outcome of practice against established standards, and to institute appropriate action to achieve and maintain quality. 2. A systematic process for closing the gap between actual performance and desirable outcomes. 3. Continuous quality improvement is a management method that seeks to develop the organisation in an orderly and planned fashion, using participative management, and has at its core the examination of process.
Recruitment and retention	The process used to attract, hire and retain qualified staff. Retention strategies may include reward and recognition programmes.
Reliability	The ability of an indicator to accurately and consistently identify the events it was designed to identify across multiple healthcare settings.
Research	Critical and exhaustive investigation of a theory or contribution to an existing body of knowledge aimed at the discovery and interpretation of facts.
Responsibility	The obligation that an individual assumes when undertaking delegated functions. The individual who authorises the delegated function retains accountability.
Risk	Exposure to any event that may jeopardise the client, staff member, physician, volunteer, reputation, net income,

	property or liability of the organisation.
Risk management	A systematic process of identifying, assessing and taking action to prevent or manage clinical, administrative, property and occupational health and safety risks in the organisation in accordance with relevant legislation.
Safety	The degree to which potential risks and unintended results associated with healthcare are avoided or minimised.
Seamless continuum of care	In the ideal healthcare system, care is delivered in an integrated, uninterrupted or 'seamless' flow. It is defined as an integrated, client-oriented system of care composed of both services and integrating mechanisms that guides and tracks clients over time through a comprehensive array of health, mental health and social services spanning all levels of intensity of care.
Setting	The particular healthcare environment that is appropriate for the patient's needs during the continuum of care, i.e. inpatient care, outpatient attendance, rehabilitative and restorative unit~~,~~ or community setting.
Staff	All individuals employed by the facility – this includes full time, part time, casual or contract, clinical and non-clinical personnel.
Staff development	The formal and informal learning activities that contribute to personal and professional growth, encompassing induction, in-service training and continuing education.
Stakeholder	Individual, organisation or group that has an interest or share in services.
Standards	1. The desired and achievable level of performance corresponding with a criterion, or criteria, against which actual performance is measured.
Standard development	Standards for evaluation may be developed in three stages. 1. Normative development entails establishing what experts believe should happen. 2. Empirical standards reflect what is achievable in practice. 3. A compromise between what is professionally optimal and what can reasonably be expected to operate.
Standard, minimum	A predetermined expectation set by a competent authority that describes the minimally acceptable level of (a) structures in place (b) performance of a process and/or (c) measurable outcome that is practically attainable.

Standard, patient-centred	For the purposes of compliance, standards that address and are organised around what is done directly or indirectly, for or to patients (e.g. creation of patient records, patient assessment).
Standards-based evaluation	An assessment process that determines a healthcare organisation's or practitioner's compliance with pre-established standards.
Structure	The physical and human resources of an organisation.
Surveyor	A physician, nurse, administrator, or any other healthcare professional who meets Botswana surveyor selection criteria, evaluates standard compliance and provides consultation regarding standard compliance to surveyed organisations.
System	The sum total of all the elements (including processes) that interact to produce a common goal or product.
Team	A number of people with complementary skills whose functions are interdependent. They work together for a common purpose or result (outcome) on a short-term or permanent basis. Examples include project, problem-solving, quality improvement and self-managed teams. (See also multidisciplinary team and professional team.)
Timeliness	The degree to which care is provided to the patient at the most beneficial or necessary time.
User	Someone who uses or could use the services offered by the facility.
Utilisation management	Proactive process by which an organisation works towards maintaining and improving the quality of service through the effective and efficient use of human and material resources.
Utilisation review	A method of controlling utilisation that may be: Prospective (pre-admission certification) – The purpose is to assess whether hospitalisation has been justified, and is diagnosis independent. Concurrent –Conducted to assess inpatient care at the time it is provided, the use of resources, the timeliness with which treatment is provided, and the adequacy and timeliness of discharge planning. Retrospective – Follows a patient's discharge from the clinic/health centre or any patient who has received ambulatory care.
Validation of survey	A process whereby a facilitator assesses the completed self assessment documents of a facility. The validation ensures that criteria have been correctly interpreted and appropriately answered, and that the technical aspects of

	the assessment have been correctly addressed. The facilitator uses the opportunity to provide education and consultation on standard interpretation and compliance.
Vision	A short, succinct statement of what the organisation intends to become and to achieve at some point in the future.
Waste management	Collection, treatment, storage, transportation and disposal of waste material including biomedical, household, clinical, confidential and other waste.
Workload measurement	Manual or computerised tool for assessing and monitoring the volume of activity provided by a specific team in relation to the needs for the care, treatment and/or service they are providing.

Introduction

This manual contains National Health Quality Standards for Emergency Medical Services and includes guidelines for their consistent interpretation and accurate assessment.

The purpose of this manual is to serve as a guide to surveyors and facilitators, as well as emergency medical services staff. It provides information on certain key aspects pertaining to the layout of the standards and their interpretation, as well as core principles to be applied in assessing standard compliance.

The genesis of these standards has been from the internationally benchmarked medical transport standards of the Joint Commission International (JCI) in the United States, which have been adapted to a local context while retaining the level of quality demanded. Bearing in mind the high workload in many institutions, an attempt has been made to keep the standards as concise as possible.

This set of standards is a result of collaboration between health workers , representatives of providers of emergency medical services and teaching institutions in the country and the Council for Health Service Accreditation of Southern Africa (COHSASA). While the content of the standards has been chosen by people working "at the coal face" and familiar with current best practice, the structure and organization of the standards meet the requirements of the International Society for Quality in Health Care (ISQua) and they are linked to an established assessment tool and information system.

Community trauma and emergency services are best delivered when institutions form part of a trauma/ emergency system rather than operating as independent, uncoordinated elements. In order to plan a system the capabilities of individual organizations need to be catalogued; this information is then used to guide service delivery for medical transport systems and to make system wide disaster plans. The standards provide a tool to achieve this, but also provide a systematic measurement of management, training and equipment shortfalls so that scarce resources can be spent as efficiently as possible.

Although optimization of the physical environment is an important goal, excellent care can be provided with limited resources; proper training, personnel support and functional administrative structures are the most important priorities.

It is recognized that many institutions in the country start from a deprived base, and that emergency services providers may feel that the gap between the actual situation and the standards is so great that it is not worth trying to bridge it. However, standards should not be written to fit current circumstances and in situations where bringing services up to an acceptable level is a daunting prospect. Gradual improvement and consistent support will be necessary for them to achieve desired outcomes for the benefit of clients.

In adapting these National Health Quality Standards, cognizance is taken of the fact that there is currently no legislation governing Emergency Medical Services, but a draft policy document (Draft Policy Document on Pre-Hospital Medical Care and Emergency Medical Services [EMS]) has been developed. The Policy document will be guided by regulations, the implementation of which will be supported by the standards.

The standards presented here are designed to help bridge the gap between today and a better tomorrow bringing patient care quality and patient safety to new levels. Implementing standards can be an evolutionary process taking time to do things right and better.

A. Structure/Format

This set of standards consists of several Service Elements (SE's) for the various services/departments. Each Service Element contains the relevant standards and criteria (measurable elements) to be assessed in order to ascertain the level of compliance with the standards.

Information on the standards in this document has been set out in the following format and the first section of Service Element 1 - Management and Leadership - is used as an example to demonstrate the layout:

1 **1 MANAGEMENT AND LEADERSHIP**

OVERVIEW OF MANAGEMENT AND LEADERSHIP

Effective management of a health service begins with understanding the various responsibilities and authorities of individuals in the health service, and how these individuals work together.

At the governance level there is an entity.....

1.1 Governance of the health facility

1.1.1 The governing body's accountability and responsibilities are documented and are known to the health facility's managers.

Intent of 1.1.1

There is a governing body responsible for directing the operation of the organisation, which is accountable for providing quality health services to its community.....

1.1.1 Criteria

1.1.1.1 Documents describe governance, accountability and responsibilities.

Guideline: This Governance structure refers to the authority (ies) above the level of the Facility Manager and may include National/District levels in the Public Sector together with the Hospital Advisory Board, or Corporate structures in the Private Sector

With reference to the example of Service Element 1 above the table below explains the hierarchical layout and purpose of each section:

HEADINGS IN EXAMPLE ABOVE	**EXPLANATION**
1. MANAGEMENT AND LEADERSHIP:	Number and name of the service element
Overview of Management and	General description of the service

Leadership	element and context of the standards in the service element.
1.1 Governance of the organisation	The first "performance indicator" (or main section) for this service element.
1.1.1 The governing body's accountability and responsibilities are documented and are known to the health facility managers.	The first standard in this service element.
Intent of 1.1.1 There is a governing body …….	A description of the context/scope of the above mentioned standard 1.1.1. Note that the information in this intent statement forms an integral part of aspects to be considered when measuring compliance of criteria.
1.1.1 Criteria	This heading indicates that what follows is the list of criteria (measurable items) that support standard 1.1.1
1.1.1.1 Documents describe governance accountability and responsibilities.	The first criterion in this section for standard 1.1.1
Guideline in a separate block in italics	A description/explanation of what is expected and guidance on how to assess compliance with the criterion.

B: Additional Notes on the "Guidelines" (section in italics below the criteria in the above example)

Purpose/intention of the guideline statements:

The purpose of these guidelines is to provide guidance on the scope and interpretation of the criteria statements. The information should also provide facility staff (clients) with a clear indication of the requirements for compliance and some direction on the surveyors' expectations.

In some instances the guidelines also state the minimum requirements for compliance and provide direction on how to reach a decision on the compliance score.

Root criterion

Where the guideline text box contains the word "root criterion", the following applies:

- A "root" criterion is considered to be the central focus of a process or system, which is supported by several other "sub-criteria" that intend to describe the smaller components of such a system or process.

- The rating of a root criterion is dependent on the compliance rating of its supporting criteria, and should therefore reflect the aggregated average of the scores of such supporting criteria.
- This implies that a root criterion cannot be scored until such time that all its linked criteria have been assessed.

For more details on the scoring methodology for root criteria and their links, refer to item 7 in section C below.

C: Rules for assessment of compliance with criteria and the scoring system

The standards in this manual are written expectations of structures, processes or performance outcomes and it is assumed that, if these standards are met, better services/care can be delivered. The standards in turn are defined by objective, measurable elements referred to as "criteria". Criteria are given weighted values (severity ratings) according to how important the criterion requirement is in relation to various aspects (categories) such as legality, patient and staff safety, physical structure, operational effectiveness and efficiency.

Take note that assessing compliance with the standards and criteria includes various activities such as studying documentation, staff and patient interviews, patient record audits and observation of patient care processes, physical facilities and equipment.

Criteria are scored as follows:

In assessing the level of compliance with a criterion, one should not move beyond what that criterion intends to measure. **Each criterion should be assessed** individually according to the following principles:

I. **Compliant (C)** means the condition required is met. Evidence of compliance should be present in a tangible and/or observable form, e.g. written material, physical items, etc.

   a. Should the standards, for example, require a written policy and procedure but the facility has only a verbal policy in place, then the criterion should be scored as non-compliant.
   b. Should the facility have a written policy but no evidence is found of consistent implementation thereof or if there is evidence of non-adherence, then the criterion should be scored as partially compliant.

   The same principle applies in all instances where either the standards or criteria contain words such as **policies, procedures, programmes, plans, protocols, guidelines, etc.**

II. **Partially compliant (PC)** means the condition required is not totally met, but there is definite progress (>50%) towards compliance and the deficiency does not seriously compromise the standard. Other considerations for PC ratings are:

   If the criterion requires a documented system as listed above, but there is no implementation or implementation is partial or if the policy document is still in draft form.

If the criterion contains more than one requirement, e.g.: "There is a policy and procedure on the safe prescribing, ordering and administration of medicines," but not all components are compliant.

If assessment results can be quantified by means of conducting an audit, e.g.: "less than 80% of staff have received training", or "evidence was found in less than 80% of patient records audited".

Since there are degrees of partial compliance (PC), the category PC is further subdivided into four degrees of severity: mild (1), moderate (2), serious (3) and very serious (4). These can be thought of as being 80% towards compliance, 60% towards compliance, 40% towards compliance and 20% towards compliance. Obviously, the further away from compliance, the more severe the deficiency will be.

III. **Non-compliant (NC)** means there is no observable progress towards complying with the required condition. The degree of non-compliance is again scored in terms of severity, from mild (1) to very serious (4), as explained above.

IV. **Not applicable (NA)** means the criterion is not applicable because the facility either does not provide the service at all, or not at the particular level the criterion is designed to measure. Such criteria are excluded in calculating compliance scores.

V. To quantify the degree of compliance, criteria are awarded points according to their level of compliance and seriousness as follows:

Rating	Score
C	80-100
PC mild	75
PC moderate	65
PC serious	55
PC very serious	45
NC mild	35
NC moderate	25
NC serious	15
NC very serious	5
NA	Not scored

VI. Critical criteria

A standard may have one or more criteria that are marked "critical". This is where non- or partial compliance will compromise patient or staff safety, or where there are legal transgressions.

The methodology used in scoring critical criteria calls for an exception to the rule of PC ratings as described above:
Where a critical criterion is scored as PC, but it is so serious as to constitute a danger to patient and/or staff safety, is in direct contravention of an act or regulation, severely affects patient care or the efficiency of the facility, then it must be scored as NC, e.g. there is a fire alarm but it is not working. This must then be scored as NC rather than PC.

Furthermore, non-complaint critical criteria will result in the entire standard being scored as non-or partially compliant.

VII. Scoring "linked" criteria

Several criteria (either in the same SE or in different SEs) are linked with one another, either because they deal with the same system or process, they are duplications, or one of the criteria may be seen as the "root" with several other criteria focussing on "sub-components" of such a "root" criterion. Should such a linked criterion be scored NC or PC, then this may have an impact on the compliance ratings of other linked criteria. The following rules should be applied when scoring linked criteria:

- If a **critical** criterion scores NC or PC, then selected linked criteria should reflect a similar score.
- Also, if a substantial number of **non-critical** criteria linked to a critical criterion score NC or PC, the critical criterion should reflect a similar score.
- The same rule applies to criteria that relate to **legal** requirements and patient/staff **safety** matters.

The decision to apply the above will depend on the local circumstances and the consideration of the following additional rules:

- If the majority of criteria that focus on the same system or process are scored either NC or PC, then the root criterion should reflect a similar score (because this would constitute a **high-volume** deficiency) Example: if **most** of the policies and procedures in the organisation have not been reviewed, then the root criterion (1.2.4.5) is scored NC.

D: The Matrix Model

As explained above, the structure of the standards and criteria is such that many of these are "interlinked", either within the same Service Element or between the different Service Elements. "Interlinked" means that the same standard/criterion is either repeated in more than one location, or that the standard/criterion is similar to, or closely linked to another standard/criterion in terms of its meaning or in terms of the system or process that it measured.

In using the matrix, scoring rules should apply as indicated in subparagraphs 7.1 to 7.4 above.

E. Patient Record Audit

There are several criteria in the various clinical Service Elements related to the content of patient records. Such criteria are identified with the words **patient record audit** in the guideline statements. In order to assess compliance with these, a structured documentation audit needs to be conducted on a representative sample of patient records.

Surveyors are obliged to sign a Declaration of Confidentiality on appointment and they are expected to maintain the highest level of confidentiality in their handling of patient folders and dealing with patient health information.

F: Additional Comments

1. Several criteria require compliance with laws and regulations. The guideline statements for these criteria indicate that national requirements need to be considered for assessing compliance. In instances where laws/regulations do not exist for such an item, it will be expected that the facility will develop their own internal policy in accordance with internationally accepted norms and standards.

2. Any reference to "staff/personnel" in the standards and criteria should be interpreted to read all personnel employed by the facility unless otherwise stated. The requirements also apply to all health professionals who are allowed to render patient care, regardless of their employment status.

SE 1 MANAGEMENT AND LEADERSHIP

OVERVIEW OF MANAGEMENT AND LEADERSHIP

Providing excellent patient care requires effective management and leadership, which occur at various levels in a health organization. At the governance level there is an entity (for example Ministry of Health), an owner(s), or group of identified individuals (for example a board or governing body) responsible for directing the operation of the organization and accountable for providing quality health services to its community or to the population that seeks care.

Within the organization there are individuals assigned the responsibility of ensuring that the policies of governance are implemented, and that there are systems of administration and organization to provide excellent patient care. At departmental and service level, heads of departments and services ensure effective management and leadership.

Leadership comes from many sources in a health organization, including governing leaders, clinical and managerial leaders, and others who hold positions of leadership, responsibility and trust. Each organization must identify these individuals and involve them in ensuring that the organization is an effective, efficient resource for the community and its patients. In particular, these leaders must identify the organization's mission and make sure that the resources needed to fulfil this mission are available. For many organizations, this does not mean adding new resources but using current resources more efficiently even when they are scarce. Also, leaders must work well together to coordinate and integrate all the organization's activities, including those designed to improve patient care and clinical services.

Effective governance, management and leadership begin with understanding the various responsibilities and authority of individuals in the organization, and how these individuals work together. Those who provide governance, management, and/or leadership have both authority and responsibility. Collectively and individually they are responsible for complying with laws and regulations, and for meeting the organization's responsibility to the patient population served.

Over time, effective management and leadership helps overcome perceived barriers and communication problems between departments and services in the organization, and the organization becomes more efficient and effective. Services become increasingly integrated. In particular, the integration of all quality management and improvement activities throughout the organization results in improved patient outcomes.

Standards

1.1 Governance of the Organisation.

1.1.1 The responsibilities and accountability of the governance of the organisation are documented and implemented by the organisation's managers.

Standard Intent

According to the Oxford dictionary to govern is "to conduct the policy, actions and affairs of (a state, organisation or people) with authority." The same source defines governance as "the action or manner of governing a state, organisation, etc." It relates to decisions that define expectations, grant power, or verify performance. It consists of either a separate process or part of management or leadership processes".

A governing body is the group of people given the power and authority to govern an organisation. Governing bodies can take the form of a board, a council, a steering committee, or an assembly of elders or traditional owners. Their role is to plan strategic direction, set the organisation's goals, lead the organisation, make the policies and evaluate and support the management and personnel.

There is a governing body responsible for directing the operation of the health facility, which is accountable for providing quality healthcare services to its community or to the population that seeks care. The responsibilities and accountability of this entity are described in a document that identifies how they are to be carried out, and are known to those responsible for management within the health facility. The responsibilities of governing bodies lie primarily in approving plans and documents submitted by the managers of the health facility. Those elements of management requiring approval by governance are documented.

The process and practices that will apply will vary significantly given the environment in which they are applied. Governance in the public sector, which includes ministries, boards and similar entities, takes into account legal and constitutional accountability and responsibilities.

In a business or non-profit organisation governance, in addition to legal and constitutional accountability, relates to consistent management, policies, processes, guidance and decision-rights for a given area of responsibility.

It is important that the health facility has clear leadership, operates efficiently, and provides quality healthcare services. The lines of communication for achieving these goals are presented in an organisational chart or other document.

1.1.1 Criteria

1.1.1.1 Documents describe governance accountability and responsibilities.

Root criterion

Please note that the criterion requires an organisational chart of both the Governance Structure and the local organisation. This document(s) should also illustrate the relationship between the Facility Manager and the first 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 personnel who his/her direct supervisor is, and also his/her span of responsibility. It is not a requirement to reflect names of individuals. It goes without saying that – as with any other official document – the organogram should be duly authorised (dated and signed).

1.1.1.2 There is an organisational chart or document that describes the lines of authority and accountability from governance, and within the organisation.

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 1.1.1.1.

Also take note that some of this information may be contained in Acts, and National regulations. In the private sector this information may also be published as either a corporate document or on the website.

1.1.1.3 The responsibilities of governance include providing support to the personnel in the health facility.

1.1.1.4 The support from national or district managers includes regular supervisory visits, monitoring, written communications, training and development.

1.1.1.5 The organisation has a valid licence, issued by an acknowledged healthcare licensing authority, to operate as an emergency medical service.

1.1.2 *The organisation provides patient treatment and transport services within business, financial, ethical and legal norms that protect patients and their rights.*

1.1.2 Criteria

1.1.2.1 The leaders establish a framework for the ethical management of the organisation.

The leaders consider national and international ethical norms when developing the organisation's framework for ethical management. Evidence of compliance exists in the form of documented systems such as a policy framework, guidelines, position statements such as those from professional councils and associations, Acts, regulations, etc. Patient right charters are also relevant to this section. Also note the

reference in the intent to the organisation's marketing activities and the processes in relation to the admission, discharge and transfer of patients.

Although this partly refers to formal systems it also requires an organisational system/process/body, e.g. an Ethics Committee or other structure or process document.

Final assessment of this criterion is based on evidence of implementation of these principles throughout the organisation and the rating should reflect the aggregated score of relevant standards and criteria.

1.1.2.2 The organisation honestly portrays its services to patients.

There is no single aspect against which compliance is assessed and the criterion is generally rated compliant by default unless there is evidence of a very specific "transgression" such as inadequate/incorrect information to patients, complaints about accounts, serious misconduct, financial mismanagement (accounts/billing for services), dishonest/inappropriate marketing of services, etc.

1.1.2.3 The organisation provides clear policies on the selection of receiving organisations.

While transport organisations may not have responsibility for identifying receiving facilities, they would ensure during their logistical arrangements, that the receiving facility is appropriate to the clinical needs and financial abilities of the patient.

1.1.2.4 The organisation monitors the accuracy of bills.

This refers to a policy framework and the outcome as recorded in either an internal or external financial audit report.

This will be assessed from examination of the complaints register and from the auditors' reports.

1.1.2.5 There is a committee or other mechanism to oversee all research within the organisation.

Where the organisation does NOT participate in research, this is marked as NA

1.1.2.6 The organisation discloses and resolves conflicts when financial incentives and payment arrangements compromise patient care.

Where transport organisations have a vested interest in feeding patients to a specific facility, such interest needs to be overtly communicated to the patient, e.g. a verbal statement, commentary within the consent document or within vehicle branding / logos

1.1.3 *There is full disclosure of the ownership of the medical transport services organisation.*

1.1.3 Criteria

1.1.3.1 The organisation has a document explaining the details of its ownership and licensure.

This is generally evident for EMS in the public sector as well as in major private EMS groups. In some organisations this information may not be readily available, but could be found in company documents, list of the Board of Directors, etc.

1.1.3.2 The document is available via an accessible public forum.

This could be found in an annual report, company website, or other marketing material.

1.1.3.3 The document is available for all legal and/or publicly perceived organisational names.

This could be found in an annual report, company website, or other marketing material.

1.1.3.4 The document reveals any corporate or individual business or financial relationships that could be perceived as potential conflicts of interest, incentives, and/or payment for referrals.

This could be found in an annual report, company website, or other marketing material.

1.2 Senior Management and Medical Direction

1.2.1 *A medical director with appropriate registration, education, and training provides oversight of the medical activities of the emergency medical services organisation.*

Standard Intent

Each organisation employs or otherwise obtains the services of a medical doctor (supervising medical officer), who is accountable for oversight of the medical activities that take place within the organization. To accomplish these oversight responsibilities, the medical director must have training and experience related to emergency medical services. The individual selected or appointed by the governing body to carry out these functions has the necessary qualifications such as the Diploma in Primary Emergency Care, Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), Advanced Paediatric Life Support (APLS), etc.

1.2.1 Criteria

1.2.1.1 There is an appropriately licensed and trained medical director who is accountable for the oversight of all medical activities of the organisation.

Medical direction should be provided through an external party contracted to provide this oversight to the organisation, or through a full time appointee.

The organisation has documentation, e.g. approved job description detailing the required qualifications, licensure, and experience

The organisation has a process to orient the appointee to their role and responsibilities in the organisation, specific to EMS oversight

1.2.1.2 The medical director is accountable for the development, implementation, and monitoring of clinical dispatch functions.

Part of the documented job description includes dispatch interrogation, prioritisation, and pre-arrival instructions.

1.2.1.3 The medical director is accountable for the development, implementation, and monitoring of all patient care and transport protocols.

Such protocols are subject to the organisations policy review process.
Such policies are included in relevant staff orientation processes.

1.2.1.4 The medical director is accountable for the training and development and clinical performance monitoring of employees that provide medical care.

Proof of such monitoring should be found in documents reporting objective evaluation of skill levels.

1.2.1.5 The medical director is accountable for the medical components of the quality management and improvement programme.

The medical director should be responsible for developing the clinical performance indicators that are monitored within the organisation.

The medical director should be responsible for the development of clinical audit tools and for the oversight of the audit process implemented.

1.2.1.6 The medical director and the managerial leaders select clinical practice guidelines.

The director ensures that clinical practice guidelines meet the minimum criteria prescribed by law or regulatory bodies. The director ensures that clinical practice guidelines consider international 'best practice'. The director ensures that clinical practice guidelines are appropriate for the clinical needs of the patient population in the organisations catchment area. Such guidelines are provided on media for each individual practitioner in the organisation. Such guidelines are implemented and communicated to staff.

1.2.1.7 The medical director and the managerial leaders adapt guidelines as appropriate for the patients served by the organisation and the resources available within the organisation.

1.2.1.8 Guidelines are used in clinical monitoring as part of a structured clinical audit.

1.2.1.9 Guidelines are reviewed and adapted on a regular basis after implementation.

Such guidelines are subject to the organisations and national regulatory body's policy review process.

Such guidelines and periodic changes are included in relevant staff orientation processes.

1.2.1.10 There is a quality control programme for point of care (POC) tests conducted by the organisation that meets, or exceeds, the manufacturer's recommendations.

Proof of compliance should include documented process guidelines, POC test result documentation (e.g. checklists), and proof of IPM.

1.2.2 *The organisation's medical direction and senior management are collectively responsible for defining the organisation's mission and creating the plans and policies needed to fulfil the mission.*

Standard Intent

The identification of individual responsibilities does not ensure good management: communication and cooperation are required between those who govern, those who manage and those who use the service, particularly when the policy making structure is separated from the operational facilities.

1.2.2 Criteria

1.2.2.1 Organisation leaders plan with the community leaders and the leaders of other organisations to meet the community's emergency and medical transport system needs.

Documentation that should be assessed includes an assessment of the current healthcare infrastructure and facilities for both upgrade and downgrade of care.

Private EMS services may have contracts detailing scope of service wherein the expected services for the relevant 'community' are detailed.

It is understood that, in many cases, ambulance services may not be readily available, but there should also be evidence of negotiations to relieve such a situation. Alternative arrangements will be assessed as to suitability and effectiveness.

This should include collaboration toward the community's emergency (disaster) planning initiatives. For this to be measured, minutes of such meetings, action plans and policies should be available. Additional proof may be reports of community disaster exercises in which the organisation participated.

Related Criteria:
EMS Criterion 5.1.3.9 guideline
Clinic standards Criterion 3.7.1.2 guideline

1.2.2.2 The organisation plans community education consistent with its mission, services, and patient population.

1.2.2.3 The organisation's medical direction and senior management leaders collaborate to provide uniform care processes.

Documentation that should be assessed includes policies detailing standards of patient assessment, clinical documentation, and proof of audit activities / compliance.

Related Criteria:
EMS Criteria1.2.1.6&1.2.1.8 guidelines

1.2.2.4 Similar care is provided in all patient care settings.

Documentation that should be assessed includes policies detailing standards of patient assessment, clinical documentation, and proof of audit activities / compliance.

Related Criteria:
EMS Criteria1.2.1.6&1.2.1.8 guidelines

1.2.2.5 Protocols not to treat or transport are developed by senior management in conjunction with, and approved by, medical direction.

Documentation that should be assessed includes policies detailing standards of patient assessment and treating and proof of compliance. Recommended organisational audit criteria/KPIs should be used.

Related Criteria:
EMS Criteria1.2.1.6&1.2.1.8 guidelines

1.2.2.6 Treat and release procedures are developed in conjunction with and approved by medical direction.

As above

1.2.3 *The organisation's medical direction and senior management ensure that policies and procedures, which support the activities of the organisation, are put into practice.*

Standard Intent

The leaders ensure that all policies which apply to various departments, services and functions of the organisation are available to the staff, and that they are put into practice and monitored. Leaders should make sure that policies and

procedures are available to guide staff in areas such as the management of resources, financial practices, and human resource management.

1.2.3 Criteria

1.2.3.1 The leaders ensure that there are policies and procedures to guide and support the different services offered by the organisation.

This element reflects the need for the organisation to document its' processes.
This element also requires the organisation to be able to demonstrate its' document management system / process.

Assessors may request copies of specific policies and may assess staff awareness during interview sessions.

Related Criteria:
EMS Criteria1.2.1.6&1.2.1.8 guidelines

1.2.3.2 Policies and procedures are correctly filed and indexed.

1.2.3.3 Policies and procedures are signed and dated by persons authorised to do so.

1.2.3.4 There is a process to ensure that staff and key volunteers are familiar with relevant policies and procedures.

1.2.3.5 Each policy and procedure is reviewed when indicated and then dated and signed.

The organisations document management process should address policy development, collaboration and review.

1.2.4 *The medical director identifies policies and procedures to guide the care of high-risk patients and the provision of high-risk services.*

1.2.4 Criteria

1.2.4.1 The organisation's medical direction and managerial leaders have identified high-risk patients and services.

There is a process to classify and identify vulnerable populations, and to categorise services and procedures by risk profiles.

Assessment of this element (and the criteria following) consists of review of the applicable policies, and should include assessment of implementation during staff interviews.

1.2.4.2 A collaborative process was used to develop applicable policies and procedures.

1.2.4.3 Policies and procedures guide the care of emergency patients with critical needs.

1.2.4.4 Policies and procedures guide the use of resuscitation services throughout the organisation.

1.2.4.5 Policies and procedures guide the handling, use and administration of blood and blood products.

1.2.4.6 Policies and procedures guide the care of patients who are on life support or are comatose.

1.2.4.7 Policies and procedures guide the care of patients with communicable disease and immune-suppressed patients.

1.2.4.8 Policies and procedures guide the use of restraint and the care of patients in restraints.

1.2.4.9 Policies and procedures guide the care of vulnerable elderly, disabled and paediatric patients.

1.2.4.10 Staffs are trained in the policies and procedures.

1.2.5 *The medical director manages and is accountable for the medical care aspects of the emergency medical dispatch (EMD) system.*

Standard Intent

The dispatch centre is the first point of contact for members of the public requesting emergency help. The dispatchers perform two critical functions: the prioritizing of requests for service and the issuing of interim advice to the caller. These functions must be supervised and controlled by medical direction.

1.2.5 Criteria

1.2.5.1 The medical director is responsible for the clinical decisions and care rendered by the emergency medical dispatchers (EMDs).

The medical director's job description reflects clinical oversight of the dispatch centre.

1.2.5.2 The medical director approves and controls the EMDs' priority reference system.

The chosen tool for priority dispatch, manual or electronic, has been assessed and approved for use by the medical director.

The individual priority protocols are approved for use by the medical director. Revision of these protocols follows the organizations document review policy.

1.2.5.3 The protocol used by EMDs to dispatch aid to medical emergencies includes systematized caller interrogation questions.

1.2.5.4 The protocol used by EMDs to dispatch aid to medical emergencies includes systematized dispatch life support instructions.

1.2.5.5 The protocol used by EMDs to dispatch aid to medical emergencies includes systematized coding protocols that match the evaluated need with the vehicle response mode.

Assessment of this criterion requires understanding the development cycle of such protocols. Where the organisation has adopted a commercial product for use, the product should be able to demonstrate compliance with either an international standard or to a 'best practice' guideline.

Assessment should include proof of implementation by means of a case review.

1.2.5.6 The medical director is responsible for the evaluation of medical care and pre-arrival instructions rendered by the EMD personnel.

There is a process to audit dispatch cases which includes review of voice recordings Audit results are distributed to the relevant line managers, and are used to inform continuous development activities.

1.2.5.7 Managers' measure compliance with protocol through on-going random case reviews for each EMD.

1.2.6 There is a method for medical direction to oversee the organisation's medication list and medication use.

1.2.6 Criteria

1.2.6.1 Medications available are appropriate to the organisation's mission, patient needs and services provided.

1.2.6.2 A collaborative process was used to develop the list (unless determined by regulation or an agency outside the organisation).

High risk medications, e.g. concentrated electrolytes, are identified, and specific precautions put in place to regulate their use.

1.2.6.3 There is a method for oversight of medication use within the organisation, under the responsibility of medical direction.

1.2.6.4 Accountability for tracking medications is assigned to one or more individuals by medical director.

1.2.7 Medication is stored in a locked storage device or cabinet that is accessible only to authorised personnel.

1.2.7 Criteria

1.2.7.1 Medications identified for special control (by law or organisational policy) are stored in a cabinet of substantial construction, for which only authorised personnel have the keys.

1.2.7.2 Medications identified for special control (by law or organisational policy) are accurately accounted for.

There are guidelines limiting access to medications to those authorised to handle such.
Current laws and regulations or organisational policy will determine the nature of these medications identified as requiring special control

Compliance needs to be measured against the national medicine control regulations. Control measures generally include keeping medicine registers for these items

1.2.7.3 The organisation has identified those adverse effects that are to be recorded in the patient's record and those that must be reported to the relevant authorities.

Patient record audits should reveal whether the effect of medications, where relevant, was monitored, recorded, and brought to the attention of the senior attendant.

The incidence and intensity of therapeutic and undesirable effects needs to be monitored. While clinical signs and symptoms are useful measures of drug therapy efficacy, additional information may be required.

An adverse drug reaction (abbreviated ADR) is an expression that describes harm associated with the use of given medications at a normal dose. The meaning of this expression differs from the meaning of "side effect", as this last expression might also imply that the effects can be beneficial. The study of ADRs is the concern of the field known as pharmacovigilance.

1.2.7.4 The organisation defines a medication error.

1.2.7.5 Medication errors are reported in a timely manner using an established process.

A process needs to be in place for reporting and recording of medication errors. These include errors in relation to prescribing, dispensing and administering medication.

1.2.7.6 The organisation uses medication error reporting information to improve medication use processes.

1.3 Facility Management

1.3.1 A manager is responsible for operating the facility and for complying with applicable laws and regulations.

Standard Intent

A designated manager is identified and is responsible for day to day operational function of the facility (ambulance station). The organisation's governance and management structure is presented in an organizational chart or other document. Lines of authority and accountability are shown in this document.

1.3.1 Criteria

1.3.1.1 A manager is responsible for the day-to-day operation of the facility.

The applicable job description designates these responsibilities.

1.3.1.2 The manager has the education and experience to carry out his or her responsibilities.

1.3.1.3 The manager recommends policies to the governing body.

1.3.1.4 The manager carries out approved policies.

1.3.1.5 The manager ensures compliance with applicable laws and regulations.

1.3.1.6 The manager responds to any reports from inspecting and regulatory agencies.

1.3.1.7 The manager or director manages human, financial and other resources.

1.4 Response and Deployment Plan

1.4.1 The organisation has a comprehensive response and deployment plan consistent with its mission and resources.

Standard Intent

A comprehensive response and deployment plan addresses location of facilities and distribution of vehicles, staff, i.e. including number and qualification and other resources. These should be deployed in a way that optimises their utility and provides uniform care across the area served.

1.4.1 Criteria

1.4.1.1 The organisation has a written response and deployment plan including the identification of response areas and availability of response units.

Linked criterion: *7.5.1.1*

1.4.1.2 The plan includes coordination with other governmental, private, public safety and/or military agencies, and the appropriate conditions for turning patients over to these agencies.

1.4.1.3 The organisation designs and implements processes to provide coordination of services among other organisations and agencies in the community.

1.4.1.4 Actual demand has been reviewed against the plan.

1.4.1.5 When necessary, the plan is adjusted accordingly.

1.4.1.6 The plan includes coverage of peak periods.

There is a process to address overflow of cases, which identifies alternative agencies to whom such cases will be referred.

An inter-agency agreement may need to be signed agreeing to the nature of the assistance.

1.4.1.7 The plan includes response to multiple-victim incidents.

The plan must specify the Incident Command System (ICS), and who the lead agency is during such incidents.

1.4.1.8 The plan includes disaster response.

There is a need to reflect that these plans are tested regularly.

1.4.1.9 The response and deployment plan includes response time standards.

1.4.1.10 The response time standards meet local, regional or national laws and regulations.

1.5 Oversight of Contracted Services

1.5.1 The leaders provide oversight of contracts.

1.5.1 Criteria

1.5.1.1 There is a process for leadership oversight of contracts.

The process is spelt out in a contract management policy which specifies oversight and approvals process.

1.5.1.2 Services provided under contracts and other arrangements meet patient needs.

Service level targets are specified in contracts and or Service Level Agreements (SLAs)

1.5.1.3 Contracts and other arrangements are monitored as part of the organisation's quality management and improvement programme.

There is a document detailing current contracts, responsible parties, expiry dates. SLAs may inform organisational quality indicators.

SE 2 HUMAN RESOURCE MANAGEMENT

OVERVIEW OF HUMAN RESOURCE MANAGEMENT

A health organisation needs an appropriate number of suitably qualified people to fulfil its mission and meet patient needs. The organizations' clinical and administrative leaders work together to identify the number and types of staff needed based on the recommendations from departmental managers.

Recruiting, evaluating and appointing staff is best accomplished through a co-ordinated, efficient and uniform process. It is also essential to document applicant skills, knowledge, education and previous work experience. It is particularly important to carefully review the credentials of clinical personnel because they are involved in clinical care processes and work directly with patients.

Health organisations should provide staff with opportunities to learn and advance personally and professionally. Thus, in-service education and other learning opportunities should be offered to staff.

Standards

1.2 Personnel Management

2.1.1 Adequate and competent personnel are available to provide a safe and effective emergency medical service.

Standard Intent

A staffing plan reflects the knowledge, skills and availability of personnel required to provide an effective service.

Personnel act in accordance with job descriptions/ performance agreement, and are evaluated in accordance with their assigned responsibilities. The in-service training needs of personnel in the service are continuously assessed and appropriate training provided to ensure a safe and effective service.

2.1.1 Criteria

2.1.1.1 There is a documented process for staffing the emergency medical service.

It is preferable that all these aspects be summarised in an executive-type summary for ease of access to relevant information. However, this does not preclude the presentation of separate documents related to various structured processes that are guided by policies, procedures, protocols or narratives and should be needs based.

The plan should be available either as part of the strategic planning process or as an operational plan. The plan should include the current personnel establishment, i.e. posts available, posts filled and posts vacant.

The personnel establishment should be based on scientific findings, e.g. analysed work-study findings, catchment area population, etc. The study may be conducted in house or by an independent agent.

Staffing levels for professional personnel should be based on accepted national or international norms/standards.

2.1.1.2 The desired education, qualifications, skills and knowledge are defined for all personnel.

The organisation complies with laws and regulations that define the desired educational levels, skills or other requirements of individual staff members, or define staffing numbers or the mix of personnel for the organisation. The organisation considers the mission of the organisation and the needs of the population served in addition to the requirements of laws and regulations.

Related criteria:
EMS 3.1.1.2

2.1.1.3 Each employee in the service has a written job description performance agreement, which defines their responsibilities.

The responsibilities of individual staff members are defined in current job descriptions / performance agreement.

The job description/performance agreement provides details of accountability, responsibility, formal lines of communication, principal duties and entitlements. It is a guide for an individual in a specific position within an organisation. Key performance areas should be included in order to evaluate the staff member's performance.

Personnel are required to sign a current job description following any changes during periodic review of the job descriptions' scope.

2.1.1.4 There is at least one documented evaluation of personnel each year, or more frequently, as defined by the service.

The process for and the frequency of the on-going evaluation of the abilities of the personnel is defined. On-going evaluation ensures that training occurs when needed and that the staff member is able to assume new or changed responsibilities. While such evaluation is best carried out in an on-going manner, there is a least one documented evaluation each year for each staff member.

2.1.1.5 New staff members are evaluated in accordance with the policies determined by the service.

2.1.1.6 The department or service to which the individual is assigned conducts the evaluation.

2.2 Personnel Orientation and Training

2.2.1 The manager of the emergency medical service ensures that there is a written, planned and organised orientation and induction programme available for new personnel.

Standard Intent

The decision to appoint an individual to the personnel of a service sets several processes in motion. To perform well, a new staff member needs to understand the entire service and how his or her specific responsibilities contribute to the service's mission. This is accomplished through a general orientation to the service and his or her role in the service, and a specific orientation to the job responsibilities of his or her position.

2.2.1 Criteria

2.2.1.1 There is a written, planned orientation and induction programme for new personnel.

The organisation has a generic/macro orientation programme for all employees and evidence of participation is available in the individual's personnel record or other training record.

Each department/service has established a service-specific orientation programme and evidence of participation is available in the individual's personnel record or other training record.

Even if there is only person in a department, he/she should plan and document an orientation and induction programme in the event that additional personnel should become available in the future.

2.2.1.2 The orientation and induction programme introduces new personnel to relevant aspects of the Emergency Medical Services and governance structures.

2.2.1.3 The orientation and induction programme explains the relationships and lines of authority and communication within the service and collaboration with other relevant directorates.

2.2.1.4 The orientation and induction programme prepares personnel for their roles and responsibilities in the Emergency Medical Services.

2.2.1.5 The orientation and induction programme introduces personnel to the applicable legislation and policies and procedures of the Emergency Medical Services

2.2.2 The management of the Emergency Medical Service (EMS) ensures the provision of written in-service training programmes for personnel relating to issues relevant to the needs of the individual and to the objectives of the service.

Standard Intent

The service has a responsibility to ensure that personnel are educated in matters which effect their functioning in the specific organisation. Education is relevant to each staff member as well as to the continuing advancement of the organisation in meeting the community's needs and maintaining acceptable personnel performance, teaching new skills, and providing training on new equipment and procedures. There is documented evidence that each staff member who has attended training has gained the required competencies.

The leaders of the organisation support the commitment to on-going in-service education by making available space, equipment and time for education and training programmes.

2.2.2 Criteria

2.2.2.1 There is a system for identifying the needs of emergency service personnel for in-service training, consistent with EMS objectives and the development of individual staff members.

Examples of sources which can be used for establishing training needs are:
- *job observations*
- *performance reviews*
- *annual training 'wish-lists and*

- *results from document audits.*

2.2.2.2 There is a written in-service training programme for personnel in the EMS, which is co-ordinated with the in-service training programme of the district.

The organisation has a generic/macro in-service education programme for all employees and evidence of participation is available.

It is preferable that a summarised plan is provided for ease of access to relevant information. However, this does not preclude the presentation of separate documents related to various education and training programmes and should be needs based.

2.2.2.3 The in-service training programme ensures that all personnel are competent and updated when new systems or equipment are installed or new policies, procedures or legislation are introduced.

2.2.2.4 The in-service training programme includes management training.

2.2.2.5 The Emergency Medical Services manager ensures, that personnel of the service are familiar with the district's/directorate's/cluster's and council's emergency plans and attend rehearsals at least annually.

2.2.2.6 The Emergency Medical Services manager ensures that personnel attend training on health and safety.

2.2.2.7 There is a system to ensure that all personnel in the service participate in in-service training programmes, and that records are kept.

Evidence of on-going in-service education must be submitted by means of analysed attendance data.

Refer to skills development, continuing education strategies and service-specific programmes to evaluate relevance.

2.2.3 The management of the emergency medical service ensures that continuing professional development is supported.

Standard Intent

There is a process for informing the personnel of opportunities for continuing education and training, participation in research and investigational studies, and to acquire advanced or new skills. These opportunities may be offered by the health facility, by a staff member's professional or trade association, or through educational programmes in the community. The health facility supports such opportunities as appropriate to its mission and resources. Such support may be given through tuition support, scheduled time away from work, recognition for achievement and in other ways.

2.2.3 Criteria

2.2.3.1 There is a system for identifying and addressing the training needs of EMS personnel, consistent with the EMS objectives.

This refers specifically to professional personnel and the requirements for continued registration with the relevant professional bodies, where applicable. Management must have a strategy for assisting professional personnel to maintain their continued registration.

2.2.3.2 The continuing education plan ensures the provision of information on advances in practice relating to EMS.

Examples of this could include resuscitation guideline Linked to Standard 2.4.2

2.2.3.3 The plan ensures adequate opportunity to fulfil requirements for continued registration with the professional regulating body.

2.2.3.4 Current information is available to EMS personnel, to enable them to keep updated in their relevant fields of work.

2.2.3.5 The EMS facilitates the attendance of EMS personnel at relevant conferences, meetings or seminars.

2.2.3.6 Records of attendance are kept.

2.2.4 Where students are trained as part of undergraduate or postgraduate programmes, the Emergency Medical Service ensures formal training.

2.2.4 Criteria

2.2.4.1 There is a designated member of the personnel of the EMS who co-ordinates student internship.

2.2.4.2 The training programme is structured in accordance with the guidelines of the appropriate registration body and training centres.

2.2.4.3 Training periods are recorded and evaluated for effectiveness.

2.3 Industrial Relations

2.3.1 Sound industrial relations, which are based on current labour legislation, are implemented and maintained in the organisation.

Standard Intent

Consistent application of fair labour practice, grievance and disciplinary procedures, and dismissal, demotion and retrenchment policies and procedures is essential to prevent labour unrest, with its consequent negative effects on patient care. Membership of staff in trade unions and/or health professional organizations must be encouraged, and there must be negotiation and consultation between these bodies, management of the organisation and the staff to promote harmonious working relationships. Current employment policies need to be known and applied.

The organisation's leaders thus have a responsibility to:

- be conversant with all current labour laws and regulations
- educate personnel managers in relevant aspects of labour law
- ensure that policies and procedures are developed, and
- ensure that these policies and procedures are effectively implemented.

2.3.1 Criteria

2.3.1.1 There are mutually agreed policies and procedures with the staff for the satisfactory conduct of industrial relations activities.

Minutes attesting to the liaison activities are available for viewing.

2.3.1.2 Written disciplinary procedures, which meet the requirements of current legislation, are available.

2.3.1.3 There is a grievance procedure in terms of current legislation.

2.3.1.4 There are dispute and appeal procedures.

The assessors may require access to the documented proceedings of a recent disciplinary case to measure against the organisations procedures.

2.3.1.5 There are recognition agreements for trade unions and/or health professional organisations.

2.4 Credentialing of Staff

2.4.1 The organisation has an effective process for gathering, verifying and evaluating the credentials (license, education, training and experience) of those health professionals who are permitted to provide patient care without supervision.

Standard Intent

The organisation needs to ensure that it has qualified health professional staff that appropriately matches its mission, resources and patient needs .To ensure such a match, the organisation evaluates staff members' credentials at the time of their appointment.

An individual's credentials consist of an appropriate current registration, completion of professional education, and any additional training and experience. The organisation develops a process to gather this information, verify its accuracy where possible, and evaluate it in relation to the needs of the organisation and its patients. This process can be carried out by the organisation or by an external agency such as a ministry of health in the case of public organizations. The process applies to all types and levels of employed persons (employed, honorary, contract and private practitioners).

Evaluating an individual's credentials is the basis for two decisions: whether this individual can contribute to fulfilling the organisation's mission and meeting

patient needs, and, if so, what clinical services this individual is qualified to perform.

These two decisions are documented, and the latter decision is the basis for evaluating the individual's on-going performance. Following appointment, the organisation confirms the qualifications of professional staff, including the authenticity of qualifications and licensure and their experience and competence. This includes clinical qualifications and also qualifications to operate vehicles. The process takes into account relevant laws and regulations.
Note link to criteria 10.4.1.1 and 10.4.2.2.

2.4.1 Criteria

2.4.1.1 Those permitted by law, regulation and the organisation to provide patient cares, without supervision, are identified.

2.4.1.2 The registration, education, training and experience of these individuals are documented.

2.4.1.3 Such information is verified from the original sources when possible.

2.4.1.4 There is a record on every healthcare professional staff member.

2.4.1.5 The record contains copies of any required registration certificate(s).

2.4.1.6 There is a process to review the records annually.

The organisation specifies which documents must be contained in the employees record.

The organisation has a process for auditing each employee file

The organisation specifies who is responsible for each audit level.

2.4.1.7 A determination is made about the current qualifications of the individual to provide patient care services.

The qualification levels are specified in the relevant job specification.

2.4.2 Staff members who provide patient care and other staff identified by the organisation are trained in basic or advanced cardiac, paediatric and trauma life support, as appropriate for their job description.
(Note link to criteria 10.4.1.1 and 10.4.2.2.)

2.4.2 Criteria

2.4.2.1 Staff members to be trained in life support techniques are identified.

The requirements are specified in the relevant job specification.
Linked to criterion 2.2.3.2

2.4.2.2 The appropriate level of training is provided.

2.4.2.3 The training is repeated every two years.

Interim updates resulting from an international (ILCOR/AHA/RCSA) guidelines change should be initiated within six (6) months of such guidelines release.

2.4.2.4 There is evidence of competency for each staff member.

*Where such training is carried out externally, the organisation may not exclude these skills from the annual skill evaluation, however, if such training is provided internally (through an appropriately accredited training program), the organisation may exclude the relevant skill demonstrations from the **next** annual skill evaluation.*

The organisation identifies requirements for periodic skill competence demonstration according to the risk profile and/or volume of use for equipment and skills.

2.4.3 The organisation educates and trains all staff members about their roles in providing a safe working environment, including all facilities, equipment and vehicles.

Standard Intent

This relates to the organisations risk management processes, which are made known to personnel through appropriate training programmes and rehearsals, where applicable.

2.4.3 Criteria

2.4.3.1 For each component of the organisation's safety programme, there is planned education to ensure that staff members can effectively carry out their responsibilities.

2.4.3.2 Personnel have been trained regarding their role in internal emergencies.

Acceptable proof of compliance may include meeting minutes, attendance registers, documented emergency drills, etc.

2.4.3.3 Personnel are trained to operate and maintain medical equipment.

Clinical staffs' orientation includes required medical equipment.
Staff competence in safe and appropriate equipment use is measured at least annually.

2.4.3.4 Personnel are trained to operate and maintain communication equipment.

The use of communication equipment is included in the orientation programs for EMS and EMD staff

2.4.3.5 Personnel are trained in the maintenance of transport vehicles.

The organisations fleet management processes address maintenance related issues. Personnel who are required to use or look after vehicles are oriented as to these processes.

There are tools in use with which to document and track vehicle maintenance issues, e.g. checklists, service schedules, etc.

2.4.3.6 Personnel are trained in vehicle operating safety, including staff and patient use of seat belts.

The organisations fleet management processes address operational driving safety issues, including the use of automotive restraints.

The processes address situations where the use of automotive restraint devices are not practical, e.g. during the performance of CPR in a moving vehicle.

The organisation identifies additional driver training requirements, and shows implementation of such.

Staff who are required to use or look after vehicles are oriented as to these processes.

2.4.3.7 Personnel are oriented to appropriate operation of vehicles according to existing traffic laws.

2.4.3.8 Personnel training and testing are documented as to who was trained and tested and the results.

The organisation may show compliance in this by showing documentation related to training, e.g. certificates, or periodic skill competence assessments addressing driver competence.

2.5 Personnel Records

2.5.1 There is documented personnel information for each staff member.

Standard Intent

Each staff member in the organisation has a record with information about his or her qualifications, results of evaluations, and work history. These records are standardized and are kept current. The confidentiality of personnel records is protected. Personnel records are safely stored, and their contents are monitored to ensure completeness.

2.5.1 Criteria

2.5.1.1 Personnel information is maintained for each staff member.

2.5.1.2 Personnel files are standardised.

2.5.1.3 Personnel files are kept current.

Personnel files are subject to a standardised audit according to a predefined schedule.

2.5.1.4 Personnel files contain the qualifications of the staff member.

2.5.1.5 Personnel files contain the results of evaluations.

2.5.1.6 Personnel files contain the work history of the staff member.

2.5.1.7 Personnel files contain a record of in-service education attended by the staff member.

2.6 Debriefing

2.6.1 The organisation has a process to implement Critical Incident Debriefing.

2.6.1 Criteria

2.6.1.1 Properly trained and experienced counsellors are available to assist staff after major incidents.

The organisation may prefer to utilise external counsellors even if there are counsellors available in the organisation. This will contribute to a more conducive environment.

Staffs are informed of available resources and arrangements for use thereof.
Linked criterion:
7.2.2.3

2.6.1.2 A comfortable room where there will be no interruptions is available.

2.6.1.3 Personnel are permitted to participate in the debriefing as part of their work assignment.

2.6.1.4 Group or family debriefing sessions are arranged if indicated.

2.6.1.5 Staff may only decline a debriefing session on signing a disclaimer.

2.6.1.6 Where indicated, staff members are referred for further professional assistance.

2.6.1.7 Sources of support for the counsellor(s) are identified.

If the organisation utilises external counsellors this criteria is marked NA

SE 3 ADMINISTRATIVE SUPPORT

OVERVIEW OF ADMINISTRATIVE SUPPORT

The administrative support service provides the organisation with effective structures to support patient care. The organisation's leaders need to be able to rely on an effective and efficient administrative support system for the planning, organisation and coordination of managerial processes. Persons responsible for providing administrative support services must be suitably trained and experienced in, e.g. financial management, human resource management, and in providing equipment and supplies.

The administrative service is frequently the window to the public, i.e. admission and discharge systems, and sending and collecting accounts.

The administrative support system ensures an effective filing and storage system for all records, including financial, staff and patient records.

Standards

3.1 Financial Management Support

3.1.1 Budgeting, reporting and auditing processes are consistent with statutory requirements and accepted standards.

Standard Intent

Financial planning and management needs to be conducted by a person who is suitably qualified and experienced in all matters relating to the organisation's finances .Clinical and other leaders need to be included in planning their financial requirements. They also require information relating to the funds available to them for the management of their departments, and up to date statements of current expenditure. Sound accounting and auditing practices are implemented to ensure transparency. Financial managers improve their services through quality improvement methods.

3.1.1 Criteria

3.1.1.1 Financial managers ensure that policies and procedures are available to guide staff and that they are implemented.

3.1.1.2 There is a mechanism for developing budgets (e.g. cost centres) with the participation of staff.

3.1.1.3 A report is produced monthly for the organisation's management, setting out the financial position to date.

3.1.1.4 There is a mechanism for establishing the reason for budget variation in either income or expenditure.

3.1.1.5 There is a capital asset register, which is routinely maintained.

3.1.1.6 There is a capital asset replacement programme.

3.2 Provisioning and Supplies

3.2.1 There is a system to ensure that equipment and supplies are ordered, available, stored and distributed from a central point.

Standard Intent

A competent and qualified person ensures the effective administration of the provisioning department. This includes in time ordering of equipment and supplies, safe storage, prevention and notification of losses, effective distribution to departments on request, and maintenance of information relating to ordering, receipt, storage and distribution of equipment and supplies. Managers need to be assured that all equipment and supplies needed by departments will be immediately available on request. Policies and procedures guide the processes of provisioning management.

The organisation's leaders need to ensure that finances are made available for the purchase of those items of equipment and supplies which have been identified as

needed by clinical and managerial leaders. The provisioning managers therefore need to work closely with the financial manager.

3.2.1 Criteria

3.2.1.1 A designated individual is responsible for the ordering, storage, distribution and control of equipment and supplies used in the facility.

3.2.1.2 Policies and procedures guide the ordering of supplies and equipment.

3.2.1.3 Policies and procedures guide the payment for supplies and equipment received.

3.2.1.4 Policies and procedures guide the safe storage of supplies and equipment.

3.2.1.5 Policies and procedures guide the issue of supplies and equipment.

3.2.1.6 Policies and procedures guide the condemning of equipment.

3.2.1.7 Policies and procedures guide the security of order books and other face-value documents.

"Face-value" documents refer to any documents, which could present a risk if used by unauthorized persons e.g. cheque books, prescription pads, invoices books.

3.2.2 There is an information system that collects, collates and analyses information relating to the receipt and distribution of equipment and supplies.

Standard Intent

The high costs of medical supplies and equipment make it essential that sound auditing practices are in place to ensure control of the financial aspects of provisioning. A management information system must track all inventory. Expenditure on equipment and supplies is transparent, and all records must be monitored and available to managers and auditors for accounting.

3.2.2 Criteria

3.2.2.1 A record is kept of goods received and goods issued.

3.2.2.2 Records are audited.

3.2.2.3 All losses are investigated, reported and recorded.

3.2.2.4 There is an inventory of all goods stored.

3.2.3 All equipment and supplies are safely stored.

Standard Intent

The storage of equipment and supplies must allow for security, ease of access, and effective inventory taking. Acts and regulations, as well as policies and procedures, guide the storage of equipment and supplies.

The administrative support service ensures that supplies and provisions are ordered, received and timely provided to departments to meet their needs.

3.2.3 Criteria

3.2.3.1 Secure storage facilities are available.

3.2.3.2 Hazardous and flammable materials are stored in accordance with relevant regulations.

3.2.3.3 There is adequate storage space to enable rapid retrieval and removal of equipment when needed.

3.3 Health Record Maintenance

3.3.1 There is a system for storage of health records, which meets the needs of 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 health 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 confidentially and security of such information. When the retention period is complete, patient records and other data and information are destroyed appropriately.

3.3.1 Criteria

3.3.1.1 A designated individual is responsible for the storage, maintenance and retrieval of health records.

3.3.1.2 The health record manager ensures that policies and procedures are available to guide staff and that they are implemented.

3.3.1.3 Policies and procedures relate to the safeguarding of patient information against loss, damage, breach of confidentiality or use by unauthorised persons.

3.3.1.4 Policies and procedures are developed for health record destruction, specifying the criteria for selection and method of destruction of records.

SE 4 ACCESSES TO SERVICES

OVERVIEW OF ACCESS TO SERVICES

A healthcare service provider should consider the care it provides as part of an integrated system of services, health professionals, and levels of care, which make up a continuum of care. The goal is to correctly match the patient's health needs to the services available.

In order to meet the community's needs for services, the organisation needs to clearly define the boundaries of the community, and the boundaries of the services provided by the organisation, and to involve the community in the planning for care. The community needs to be provided with information relating to the services offered by the organisation, the hours at which services are offered, and how to obtain access to care. The leaders of the organisation ensure equitability of service provision through community participation.

Standards

4.1 Access to Services

4.1.1 The organisation provides information to the community served on how to appropriately contact the organisation and access its medical transport services.

4.1.1 Criteria

4.1.1.1 The organisation provides access information to the community.

4.1.1.2 The information is available to potential service users in a manner in which they can understand and easily use.

4.1.1.3 The information includes any service limitations and/or alternative emergency access points, when appropriate.

Linked criterion: *4.1.3.3*

4.1.2 The organisation has established processes to respond to enquiries from customers and the media.

4.1.2 Criteria

4.1.2.1 The organisation has a public relations access system.

4.1.2.2 The access system is made available to potential users.

4.1.2.3 The process respects patient confidentiality.

4.1.3 The organisation seeks to reduce physical, language, cultural, financial and other barriers to access and delivery of services.

4.1.3 Criteria

4.1.3.1 The organisation has identified the barriers in its patient population.

4.1.3.2 There is a process to overcome or limit barriers during the entry process.

Examples of efforts to reduce barriers may be the identification of multi-language translation services amongst own employees, Internet resources, etc.

4.1.3.3 There is process to limit the impact of barriers on the delivery of services.

Linked criterion: *4.1.1.3*

4.1.3.4 There is process for working with other community agencies to limit the impact of financial barriers on the delivery of services.

4.2 Dispatch and Communication

4.2.1 The dispatch plan includes a process for prioritising requests for transport services.

4.2.1 Criteria

4.2.1.1 The organisation has a prioritisation process for medical transport requests.

4.2.1.2 The prioritisation process uses written guidelines that determine both response level and urgency.

Call triage should be based on best practice and appropriate to the clinical needs of the patient

4.2.1.3 The process is monitored for compliance to protocol.

Dispatch records, appropriate to the service being delivered, are kept.

4.2.1.4 The guidelines are approved by the organisation's medical direction leaders.

4.2.2 There is direct communication capability between the caller and the dispatch centre and the dispatch centre and the rescue/vehicle staff at all times.

4.2.2 Criteria

4.2.2.1 Direct, immediate communication is maintained between the dispatch centre and the caller at all times.

4.2.2.2 Direct, immediate communication is maintained between the dispatch centre and the rescue/vehicle staff at all times.

4.2.2.3 The system includes call routing capability.

4.2.2.4 Call waiting times are monitored.

4.2.2.5 Process to manage overflow or peak times and multiple calls for the same incident are implemented.

4.3 Transfer between Facilities

4.3.1 There is a process for the transfer of patients between organisations to meet their continuing care needs.

4.3.1 Criteria

4.3.1.1 There is a process to transfer patients between facilities.

4.3.1.2 The process addresses situations in which transfer is not possible.

4.3.1.3 The process addresses the patient's medical needs during transfer

Including equipment, medications, etc.

4.3.1.4 During transfer, a qualified, licensed staff member monitors the patient's condition.

4.3.2 The transfer process is documented in the patient's record.

4.3.2 Criteria

4.3.2.1 The records of transferred patients note the healthcare organisation, and the name of the individual, agreeing to receive the patient.

4.3.2.2 The records of transferred patients contain notes as required by the policy of the transferring and receiving organisation.

Appropriate referral notes and investigations are provided to the transport crews for onward handover to the receiving facility.

4.3.2.3 The records of transferred patients note the reason(s) for transfer.

4.3.2.4 The records of transferred patients note any special conditions or requirements related to transfer.

4.3.2.5 The patient's condition at start and end of transfer is noted in the record or summary.

4.3.2.6 The records of transferred patients note any change of patient's condition or status during transfer.

Includes baseline vital signs and clinical examination.

SE 5 PATIENT AND FAMILY RIGHTS

OVERVIEW OF PATIENT AND FAMILY RIGHTS

Each patient is unique, with his or her own needs, strengths, values and beliefs. Health organizations work to establish trust and open communication with patients and to understand and protect each patient's cultural, psychosocial and spiritual values.

Patient care outcomes are improved when patients, and, as appropriate, their families or those who make decisions on their behalf, are involved in care decisions and processes in a way that matches cultural expectations.

To promote patient rights in a health organisation, one starts by defining those rights, followed by educating patients and the staff about those rights. Patients are informed of their rights and how to act on them. The staff are taught to understand and respect patients' beliefs and values and to provide considerate and respectful care, thus protecting the patients' dignity.

This chapter addresses processes to:

- identify, protect and promote patient rights
- inform patients of their rights
- include the patient's family, when appropriate, in decisions about the patient's care,
- obtain informed consent
- educate the staff about patient rights, and
- guide the organisation's ethical framework

How these processes are carried out in an organisation depends on national laws, regulations and charters and any international conventions, treaties or agreements on human rights endorsed.. The implementation of patient rights is dependent on the health organisation providing equitable services.

Standards

5.1 Implementation of Patient Rights

5.1.1 *The organisation provides processes that support patients' and families' rights during transport and care.*

Standard Intent

An organisation's leaders are primarily responsible for the way in which that organisation treats its patients. The leaders need to know and understand patient and family rights and their organisation's responsibilities as specified in laws, charters and regulations. The leaders then provide direction to ensure that the personnel, throughout the organisation, assume responsibility for protecting these rights. To effectively protect and advance patient rights, the leaders work collaboratively, and seek to understand their responsibilities in relation to the community served by the organisation.

Patient and family rights are a fundamental element of all contacts between the personnel of an organisation and patients and families. Thus, policies and procedures are developed and implemented to ensure that all personnel are aware of and respond to patient and family rights issues, including their role in supporting patients' and families' rights to participate in the care process.

5.1.1 Criteria

5.1.1.1 Policies and procedures guide and support patient and family rights in the organisation.

5.1.1.2 Staff are trained regarding the policies and procedures.

5.1.1.3 All patients are given information on their rights in a manner they can understand.

5.1.1.4 Policies and procedures are developed to support and promote patient and family participation in care decisions and processes.

5.1.2 The organisation takes measures to protect patient privacy.

Standard Intent

The organisation ensures that the patient's needs for privacy are respected, especially when the patient is providing personal information and undergoing clinical examination. Patients may desire privacy from other staff, other patients, and even from family members.

Medical and other health information, when documented and collected in a patient record or other form, is important for understanding the patient, his or her needs, and for providing care and services over time. The organisation respects such information as confidential, and has implemented policies and procedures that protect such information from loss or misuse. The misuse of patient information can result in the patient's loss of dignity, employment, and damage to personal or family relationships.

When the organisation takes responsibility for any or all of the patient's personal possessions brought into the organisation, there is a process to account for those possessions and ensure that they will not be lost or stolen. This process considers the possessions of emergency patients, those patients unable to make alternative safekeeping arrangements and those incapable of making decisions regarding their possessions. The organisation communicates its responsibility, if any, for the patient's possessions to patients and families.

5.1.2 Criteria

5.1.2.1 The patient's need for privacy is protected during all examinations, procedures and treatments.

5.1.2.2 The patient's need for privacy is protected when providing personal information.

5.1.2.3 The organisation respects patient health information as confidential.

5.1.2.4 Policies and procedures to prevent the loss and/or misuse of patient information are implemented.

5.1.2.5 The organisation has determined its level of responsibility for patients' possessions.

5.1.2.6 Patients' possessions are safeguarded when the organisation assumes responsibility or when the patient is unable to assume responsibility.

5.1.3 The organisation has a policy on initiating resuscitative services.

Standard Intent

Decisions about withholding resuscitative services or forgoing or withdrawing life-sustaining treatment are among the most difficult choices facing patients, families, health professionals and organizations. No single process can anticipate all the situations in which such decisions must be made. For this reason, it is important for the organisation to develop a framework for making these difficult decisions.

Such a framework:

- helps the organisation identify its position on these issues,
- ensures that the organisation's position conforms to its community's religious and cultural norms and to any legal or regulatory requirements,
- addresses situations in which these decisions are modified during care, and
- guides health professionals through the ethical and legal issues in carrying out such patient wishes.

To ensure that the decision-making process related to carrying out the patient's wishes is applied consistently; policies and procedures are developed through a process that includes many professionals and various viewpoints. The policies and procedures identify lines of accountability and responsibility and how the process is documented in the patient's record.

5.1.3 Criteria

5.1.3.1 The organisation has policies and procedures guiding staff when to initiate and when to terminate resuscitation measures in line with their scope of practice.

These policies are supported by current legislation.

5.1.3.2 The organisation has policies and procedures to guide staff encountering patient who choose to forego resuscitative or life-sustaining interventions.

5.1.3.3 Policies and procedures for initiating and terminating resuscitation are developed in conjunction with medical direction.

5.1.3.4 Policies and procedures guide staff in the handling of and the legal and regulatory requirements for clearly expired patients.

5.1.3.5 Policies and procedures guide the transport of potential organ donors without self-sustaining vital signs prior to arrival in the emergency department setting.

5.1.3.6 Transport occurs within a time frame to keep organs and tissue viable.

This criterion not only seeks to address organ donation situations, but includes scenarios such as transport and care of tissue following, for example, traumatic amputations.

5.1.3.7 The organisation supports patient and family choices to donate organs and tissues.

5.1.3.8 Staffs are trained in the policies and procedures.

5.1.3.9 The organisation's policies and procedures regarding end-of-life care conform to its community's religious and cultural norms and to any legal or regulatory requirements.

5.1.4 The organisation has processes to assess and manage pain appropriately.

5.1.4 Criteria

5.1.4.2 The organisation respects and supports the patient's right to appropriate assessment and management of pain.

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

5.1.4.4 The organisation educates health professionals in assessing and managing pain.

5.1.5 The organisation has a defined consent process and lists those categories or types of treatments and procedures that require specific informed consent.

Standard Intent

Informed consent may be obtained at several points in the care process. For example, informed consent can be obtained before the patient enters the organisation or before certain high-risk procedures or treatments.

Each organisation identifies those high-risk, problem-prone or other procedures and treatments for which consent must be obtained. The organisation lists these procedures and treatments and educates the staff to ensure that the process to obtain consent is consistent. Those who provide the treatments or perform the procedures develop the list collaboratively.

This consent process provides the information identified, and documents the identity of the individual providing the information.

5.1.5 Criteria

5.1.5.2 The organisation has a clearly defined consent process described in policies and procedures.

5.1.5.3 Policies include which healthcare providers may obtain consent.

5.1.5.4 The organisation has listed those procedures and treatments that require separate consent.

5.1.5.5 Medical direction leaders approve the list.

5.1.6 Consent is obtained, consistent with the organisation's policies and procedures.

5.1.6 Criteria

5.1.6.2 General consent is obtained at the point of first contact.

5.1.6.3 Information on the scope of such consent is provided.

5.1.6.4 Consent is obtained before the use of blood and blood products.

5.1.6.5 Consent is obtained before high-risk procedures and treatments.

5.1.6.6 The identity of the individual providing information on risks, benefits and alternatives to the patient and family is noted in the patient's record.

5.1.6.7 Consent is documented in the patient's record by signature or a record of verbal consent.

5.1.7 The organisation informs patients and families about its process to receive and act on complaints, conflicts and differences of opinion about patient care, and the patient's right to participate in these processes.

Standard Intent

Patients have a right to voice complaints about their care, and to have those complaints reviewed and, where possible, resolved. Also, decisions regarding care sometimes present questions, conflicts or other dilemmas for the organisation and the patient, family or other decision-makers. These dilemmas may arise around issues of access, treatment or discharge. They can be especially difficult to resolve when the issue involves, for example, withholding resuscitative services or forgoing or withdrawing life-sustaining treatment.

The organisation has established processes for seeking resolutions to such dilemmas and complaints. The organisation identifies in policies and procedures those who need to be involved in the processes and how the patient and family participate.

5.1.7 Criteria

5.1.7.2 Patients are aware of their right to voice a complaint and the process to do so.

5.1.7.3 Complaints are reviewed according to the organisation's mechanism.

5.1.7.4 Policies and procedures identify participants in the process.

5.1.7.5 Policies and procedures identify how the patient and family participate.

SE 6 MANAGEMENT OF INFORMATION

OVERVIEW OF MANAGEMENT OF INFORMATION

Providing patient care is a complex endeavor that is highly dependent on information. To provide, co-ordinate, and integrate services, health organizations rely on information about the science of care, individual patients, care provided, results of care, and their own performance like human, material and financial resources, information is a resource that must be managed effectively by the organisation's leaders.

Every organisation seeks to obtain, manage and use information to improve patient outcomes and individual and overall organizational performances.

Over time, organizations become more effective in:

- identifying information needs
- designing an information management system
- defining and capturing data and information
- analysing data and transforming them into information
- transmitting and reporting data and information; and
- integrating and using information.

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

Standards

6.1 Planning

6.1.1 The organisation plans and implements processes to meet the information needs of those who carry out dispatch activities or provide clinical services, those who manage the organisation, and those outside the organisation who require data and information from the organisation.

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 staff and other human and technical resources.

The plan is comprehensive and includes all the departments and services of the organisation.

6.1.1 Criteria

6.1.1.1 The organisation has a plan to meet information needs.

6.1.1.2 The plan is based on an assessment of the needs of those within and outside the organisation.

6.1.1.3 The information needs of those who carry out dispatch activities are considered in the planning process.

6.1.1.4 The information needs of those who provide clinical services are considered in the planning process.

6.1.1.5 The information needs of those who manage the organisation are considered in the planning process.

6.1.1.6 The information needs and requirements of individuals and agencies outside the organisation are considered in the planning process.

6.1.1.7 The information plan includes how the confidentiality, security and integrity of data and information will be maintained.

6.1.1.8 Medical direction participates in information technology decisions.

6.1.1.9 Senior managers participate in information technology decisions.

6.1.2 The organisation has a policy on the retention time of records, data and information.

Standard Intent

Dispatch records, recorded calls, patient records and other data are retained for a sufficient period to comply with laws and regulations and then destroyed in a manner that retains confidentiality.

6.1.2 Criteria

6.1.2.1 The organisation has a policy on the retention of dispatch records, dispatch calls, patient records and other data and information.

The process addresses the safeguarding of information in either paper and/or electronic form.

6.1.2.2 The retention process provides expected confidentiality and security.

6.1.2.3 Records, data and information are retained according to policy or laws and regulations.

6.1.2.4 Records, data and information are destroyed appropriately.

6.1.3 The information plan is implemented and supported by sufficient staff and other resources.

Standard Intent

The organisation's information management plan, once complete and approved as necessary, is implemented. The organisation provides the staff, technology and other resources necessary to implement the plan and meet the identified information needs of the healthcare providers, managers and others.

Individuals in the organisation, who generate, collect, analyse and use data and information are educated and trained to effectively participate in managing information. Such education and training enables these individuals to:

- understand the security and confidentiality of data and information
- use measurement instruments, statistical tools, and data analysis methods
- assist in interpreting data
- use data and information to help in decision making
- educate and support the participation of patients and families in care processes and
- use indicators to assess and improve care and work processes.

Individuals are appropriately educated and trained in regard to their responsibilities, job descriptions, and data and information needs.

Information management technology represents a major investment of resources for a health organisation. For this reason, technology is carefully matched to the current and future needs of the organisation, and the organisation's resources. Available technology needs to be integrated with existing information management processes, and serves to integrate the activities of all the departments and services of the organisation. This level of co-ordination requires that key clinical and managerial staff participate in the selection process. The management of the organization ensures that staff has the required supplies, registers, check lists, forms etc. required for data management.

6.1.3 Criteria

6.1.3.1 Sufficient staff supports the implementation.

6.1.3.2 Required technology and other resources support the implementation.

6.1.3.3 Strategies are implemented to meet the information needs of those who carry out dispatch activities.

6.1.3.4 Strategies are implemented to meet the information needs of those who provide clinical services.

6.1.3.5 Strategies are implemented to meet the information needs of those who manage the organisation.

6.1.3.6 Strategies are implemented to meet the information needs of individuals and agencies outside the organisation.

6.2 Aggregate Data and Information

6.2.1 Aggregate data and information support patient care, organisation management and the quality management programme.

Standard Intent

Individual facilities submit statistical data on a regular basis, but this must be aggregated and analyzed to produce a profile of the organisation over time, to allow comparison between facilities in the same organisation and to allow the organisation to compare its performance with other organizations regionally, nationally and internationally.

6.2.1 Criteria

6.2.1.1 The organisation has a process to aggregate data and has determined what data and information are to be regularly aggregated to meet the needs of medical direction and managerial staff in the organisation and agencies outside the organisation.

6.2.1.2 Aggregate data and information support patient care.

6.2.1.3 Aggregate data and information support organisation management.

6.2.1.4 Aggregate data and information support the quality management programme.

6.2.1.5 The organisation provided needed data to agencies outside the organisation.

6.2.1.6 The organisation contributes data or information to external databases in accordance with laws or regulations.

6.2.1.7 The organisation compares its performance using external databases.

6.2.1.8 Security and confidentiality of patient-specific data and information are maintained when contributing to or using external databases.

6.3 EMS Dispatch Records

6.3.1 The organisation initiates and maintains dispatch records for each request for service.

6.3.1 Criteria

6.3.1.1 The organisation maintains a dispatch record for each request for service.

6.3.1.2 The record includes the location of the incident.

6.3.1.3 The record includes call-back information.

6.3.1.4 The record includes the type and nature of the request.

6.3.1.5 The record includes any pre-arrival information, if needed.

6.3.1.6 The record includes identification of the vehicle responding to the request.

6.3.1.7 The record includes assistance from any other agency, if needed.

6.3.1.8 All voice calls are recorded for recovery at a later stage.

6.3.1.9 All voice calls are backed up at a remote site.

6.4 Clinical Records

6.4.1 *The organisation initiates and maintains a clinical record for every patient assessed or treated which is protected from loss, destruction, tampering and un-prescribed access or use.*

6.4.1 Criteria

6.4.1.1 A clinical record is initiated for every patient assessed or treated by the organisation.

6.4.1.2 Patient clinical records are maintained through the use of an identifier unique to the patient or some other effective method.

6.4.1.3 Records and information are protected from loss or destruction according to documented policies and procedures.

6.4.1.4 There is provision for authorised access to patient records at all times.

6.4.1.5 Storage space for health records is secure against unauthorised entry.

6.4.1.6 Records and information are protected from tampering and un-prescribed access or use according to documented policies and procedures.

6.4.1.7 Access is consistent with organisation confidentiality and security policies.

6.4.1.8 Records, data and information are destroyed appropriately.

6.4.2 Organisation policy identifies those authorised to make entries in the patient record and determines the record's content and format.

Standard Intent

Each organisation has a process to assess the quality and completeness of patient records. That process is a part of the organisation's performance improvement activities and is carried out regularly. Clinical record review is based on a representative sample (a sample representing the practitioners providing care and of the types of care provided).The medical staff, nursing staff, and other relevant clinical professionals, who are authorized to make entries in the patient record, conduct the review process. The focus of the review is on the quality of the record and clinical information available during the care process. Thus, the organisation's record review process includes the review of the records of patients currently receiving care as well as the records of discharged patients.

6.4.2 Criteria

6.4.2.1 The specific content of patient records has been determined by the organisation.

6.4.2.2 Those prescribed to make entries in the patient record are identified in organisation policy.

6.4.2.3 The format and location of entries are determined by organisation policy.

6.4.2.4 There is a process to ensure that only authorised individuals make entries in patient records.

6.4.3 Record content is sufficient to meet clinical needs.

6.4.3 Criteria

6.4.3.1 Patient records contain adequate information to identify the patient.

6.4.3.2 Patient records contain adequate information to determine the patient's medical needs.

6.4.3.3 Patient records contain adequate information to justify the care and treatment.

6.4.3.4 Patient records contain adequate information to document the course and results of treatment.

6.4.3.5 Patient records contain adequate information about the patient's disposition.

6.4.3.6 The author of each patient record entry can be identified.

6.4.3.7 The date of each patient record entry can be identified.

6.4.3.8 When required by the organisation, the time of an entry can be identified.

6.4.3.9 Standardised diagnosis codes, according to national guidelines, are used.

6.4.3.10 Procedures are noted in standardised format.

6.4.3.11 Standardised symbols and definitions and abbreviations are used.

6.4.4 Treat and release and non-treat, non-transport occurrences are documented.

6.4.4 Criteria

6.4.4.1 Treat and release and non-treat, non-transport occurrences are documented.

6.4.4.2 The clinical record contains a description of the patient's physical and clinical status.

6.4.4.3 The clinical record contains the criteria used to determine the patient's competence.

6.4.4.4 The clinical record contains a description of the treatment rendered.

6.4.4.5 The clinical record contains a description of options for follow-up care, including re-contacting the medical transport provider.

6.4.4.6 The clinical record contains verification and signature of the competent patient indicating that he or she understands his or her right to refuse treatment or transport, any treatment received, and any follow-up care needed.

6.4.4.7 The clinical record contains the reason for incomplete or non-treatment and non-transport.

6.4.5 As part of its performance improvement activities, the organisation regularly assesses patient record content and the completeness of patient records.

6.4.5 Criteria

6.4.5.1 Patient records are reviewed regularly.

6.4.5.2 The review uses a representative sample.

6.4.5.3 The review is conducted by clinical professionals.

6.4.5.4 The review focuses on the timeliness, legibility and completeness of the clinical record.

6.4.5.5 Record contents required by law or regulation are included in the review process.

SE 7 RISK MANAGEMENT

OVERVIEW OF RISK MANAGEMENT

Health organizations work to provide a safe, functional and supportive facility for patients, families, staff, volunteers and visitors. To reach this goal, facilities, equipment and medication must be effectively managed. In particular, management must strive to:

- identify, evaluate, reduce and control hazards and risks
- prevent accidents and injuries, and
- maintain a safe environment.

Effective management includes the planning, training and monitoring of resources needed to safely and effectively support the clinical services provided in the in-patient, day care and home care settings. All staff are educated on how to reduce risks, and how to monitor and report situations that pose risk. Criteria are used to monitor important systems and identify needed improvements.

Planning should consider the following areas in all settings, when appropriate to the activities of the organisation.

- Occupational Health and Safety (OHS) programmes – the organisation complies with legislation relating to health and safety and risk management.
- Patient Safety – vulnerable populations are protected from harm
- Fire Safety – property and occupants are protected from fire and smoke
- Emergencies – response to disasters and emergencies are planned and effective
- Hazardous Materials – handling, storage and use of flammable and other materials are controlled and hazardous waste is safely disposed of
- Security – property and occupants are protected from harm and loss.

The provision of health and safety services, emergency planning and other aspects of providing a safe environment all require staff and volunteers to have the necessary knowledge and skills for their implementation.

Standards

7.1 Risk Management Programme

7.1.1 Managers and leaders work collaboratively to develop, implement and maintain effective risk management systems in the organisation.

Standard Intent

To plan effectively, the organisation must be aware of all relevant risks. The goal is to prevent accidents and injuries, maintain safe and secure conditions for patients, families, staff, volunteers and visitors, and reduce and control hazards and risks.

Risk management includes:

- Comprehensive inspection of the facility
- Planning all aspects of the risk management programme
- Implementation of the programme
- Education of staff
- Testing and monitoring the programme, and
- Periodic review and revision of the programme.

Monitoring of all aspects of the programme provides valuable data to make improvements in the programme and further reduce risks within the organisation.

7.1.1 Criteria

7.1.1.1 Managers and leaders formulate a comprehensive risk management programme for the organisation.

7.1.1.2 One or more qualified and/or skilled and/or experienced individuals supervise the implementation of the risk management programme.

7.1.1.3 The risk management programme includes documented processes for the identification of all risks (physical, environmental, medico-legal, operational, etc.) relating to organisational processes and systems, staff, patients, visitors and physical facilities.

Linked criterion:
7.3.1.2

7.1.1.4 The risk management programme includes documented plans and actions to eliminate or reduce the identified risks.

7.1.1.5 The risk management programme includes the on-going monitoring of risks through documented risk assessments.

The organisation documents their risk assessment, identifies risks and has a process to identify mitigation steps. The process is conducted regularly. The process considers 'financial/business' risks.

7.1.1.6 Analysed data on negative incidents is used to monitor the effectiveness of the risk management programme.

7.1.1.7 The risk management programme is reviewed and updated whenever there are changes in organisational systems and processes, or physical facilities.

7.1.1.8 Management and leaders ensure the development and implementation of written policies and procedures for all risk management processes and activities.

7.1.1.9 On-going in-service training of all staff in these policies, procedures and risk management principles is documented.

7.2 Occupational Health and Safety

7.2.1 As part of the risk management programme an occupational health and safety system is implemented in accordance with current legislation.

Standard Intent

Legislation describes the health and safety measures to be implemented by organizations. In Botswana this is covered by the various legislation.

In terms of this Act, committee members and representatives must be appointed or nominated in order to ensure the safety of staff, patients and visitors. Where the staff establishment is less than fifty, the requirement for a committee falls away, but the functions must continue. This could possibly be included in the management activities and be included on the agenda of the management team.

7.2.1 Criteria

7.2.1.1 A health and safety committee, where applicable, is constituted in terms of current legislation.

7.2.1.2 The responsibilities of committee members and health and safety representatives are documented with signed acceptance.

7.2.1.3 Health and safety meetings are held at a frequency determined by legislation, and when requested by staff or management.

7.2.1.4 Written policies and procedures on all aspects of health and safety guide staff in maintaining a safe work environment.

7.2.1.5 Staff and key volunteers are formally consulted, via health and safety representatives, on matters relating to health and safety.

7.2.2 Management makes provision for occupational health services according to a documented policy framework.

Standard intent

The provision of health and safety services, emergency planning and other aspects of providing a safe environment all require staff to have the necessary knowledge and skills for their implementation.

7.2.2 Criteria

7.2.2.1 The organisation has access to the services of a knowledgeable and experienced person in the field of occupational health.

7.2.2.2 The organisation provides it staff with written policies and procedures on its provisioning of occupational health services.

The programme addresses the specific needs of the EMS services provided by the organisation, for example, the provision and specification of minimum personal protective equipment (PPE), immunization and post-exposure prophylaxis (PEP) etc.

7.2.2.3 The occupational health service includes the provision of information and training on risks specific the healthcare workers (e.g. manual handling, needle stick injuries).

Linked standard:
2.6.1 Critical Incident Debriefing

7.3 Security

7.3.1 As part of the risk management programme the organisation makes provision for the safety and security of staff, volunteers, patients, visitors and buildings.

Standard Intent

The organisation has a responsibility to ensure that staff, volunteers, patients and visitors are safe from attacks or theft by intruders. The health and safety committee identifies areas and groups that are vulnerable and require added security.

Plans are developed and implemented to provide protection. The loss of organisation property must be prevented.

7.3.1 Criteria

7.3.1.1 Management ensures the safety of staff, patients, visitors and buildings.

7.3.1.2 Security systems provide for internal and external security.

The organisation has assessed their risks and provided mitigation of identified risk factors e.g. access control systems, panic buttons, manned security services, etc.

Linked criterion:
7.1.1.3

7.3.1.3 Management of the organisation has identified those areas of the buildings where secure locks and intruder alarms should be fitted.

7.3.1.4 There is a mechanism known to staff for summoning the assistance of security/police/protection service in the case of an emergency.

7.4 Fire Safety

7.4.1 As part of the risk management programme the organisation implements structured systems to ensure fire safety.

Standard Intent

Fire is an ever-present risk in a healthcare organisation. An organisation needs to plan for:

- The prevention of fires through the reduction of risks, such as the safe storage and handling of potentially flammable materials
- Safe and unobstructed means of exit in the event of fire
- Clearly depicted fire escape routes
- Inspection reports from the local fire departments, and
- Suppression mechanisms such as water hoses, chemical suppressants or sprinkler systems. These actions, when combined, give patients, families, staff and visitors adequate time to safely exit the facility in the event of a fire or smoke. These actions are effective no matter what the age, size or construction of the facility.

The organisation's fire safety plan identifies the:

- Frequency of inspection, testing and maintenance of fire protection and safety
  systems, consistent with requirements
- Process for testing, at least twice per year, the plan for the safe evacuation of the facility in the event of a fire or smoke
- Necessary education of staff to effectively protect and evacuate patients when an emergency occurs; and
- Participation of each staff member in at least one emergency preparedness test per year.

All inspection, testing and maintenance are documented.
The organisation develops and implements a policy and plan to eliminate smoking in the organisation's facilities, or to limit smoking to designated non-patient care areas.

7.4.1 Criteria

7.4.1.1 There are structured systems and processes in place to ensure that all occupants of the organisation's facilities are safe from fire or smoke.

7.4.1.2 Documented certification (e.g. fire clearance certificate) is available from the relevant authority that the facility complies with applicable laws and regulations in relation to fire safety.

7.4.1.3 Fire-fighting equipment is available in each ambulance or other patient transport vehicle.

The organisation assesses its' specific needs for each area and provides specific guidelines as appropriate. *Specify: e.g. "A minimum 2.5 kg Fire Extinguisher, either BCG, Dry Powder or CO2, is available in each ambulance or other patient transport vehicle"*

7.4.1.4 Documentation is available that fire detection and abatement systems, as required, are inspected, tested and maintained at a frequency determined by the organisation.

7.4.1.5 Fire fighting equipment is regularly inspected and serviced at least annually with the date of service recorded on the apparatus.

7.4.1.6 Flammable materials clearly labelled and stored separately in fireproof cupboards.

7.4.1.7 Easily recognised and understood signs prohibiting smoking are displayed in areas where flammable materials and combustible gases are stored.

7.4.1.8 A floor plan is displayed, which shows the location of fire fighting equipment, evacuation routes and emergency exits.

7.4.1.9 Annual staff training in fire prevention and evacuation procedures is documented.

7.5 Emergency Planning and Disaster Response

7.5.1 The organisation develops a plan to respond to likely community emergencies, epidemics, and natural or other disasters.

Standard Intent

There are two elements to a disaster plan. Firstly, individual facilities must have emergency preparedness. Secondly, the capabilities of these individual facilities must be catalogued and integrated into a coordinated disaster plan, which involves other facilities and organizations within the community. It is this integration and coordination, which is the responsibility of senior management. The disaster plan must address closure of individual facilities.

7.5.1 Criteria

7.5.1.1 The organisation plans its response to likely community emergencies, epidemics, and natural or other disasters.

Linked to Standard 1.4.1

7.5.1.2 The organisation participates in disaster planning at local or national level as appropriate to the scope of the organisation.

7.5.1.3 The organisation communicates with allied services to ensure coordination at different levels.

The organisation liaises with other services to understand their abilities, available resources, commitment and expectations.

7.5.1.4 The disaster preparedness plan ensures that disaster response employees are well trained.

7.5.1.5 The plan provides for the provision of disaster response supplies and equipment.

7.5.1.6 Communication equipment is available in emergencies.

7.5.1.7 The plan is tested at least once a year.

7.5.2 The organisation has a plan for continued operation and communication for the dispatch centre in the event of service disruption.

7.5.2 Criteria

7.5.2.1 The plan for providing continued communication in the event of a service disruption addresses equipment failures at the dispatch centre or in the vehicle.

7.5.2.2 The plan addresses power or telephone line (incoming/outbound) failures.

7.5.2.3 The plan addresses inaccessibility to the dispatch centre.

7.5.2.4 The plan addresses vehicle failure.

7.5.2.5 The plan addresses failure or closure of the facility.

7.5.2.6 The plan is executed at least annually.

Execution of testing cannot be prescribed to say how and what level of commitment is required, but looks to see that the organisation has processes that realistically ensure that the planned recovery will work.

7.6 Exposure to Hazardous Materials

7.6.1 The organisation has a plan for the inventory, handling, storage and use of stocked hazardous materials and the control and disposal of self-generated hazardous materials and waste.

Standard Intent

Hazardous materials and wastes used and generated by the organisation are identified and safely controlled according to a plan. Such materials and wastes

include chemicals, medical gases, vehicle fuel, hazardous gases and vapours, and other regulated medical and infectious wastes.

7.6.1 Criteria

7.6.1.1 Hazardous materials and wastes are identified by the organisation and managed according to a plan.

7.6.1.2 The plan includes safe handling, segregation, storage and use.

7.6.1.3 The plan includes the proper disposal of hazardous wastes.

7.6.1.4 The plan includes the proper protective equipment and procedures during use, spill or exposure.

7.6.1.5 The plan includes the provision of material safety data sheets (MSDS) for those hazardous materials used by the organisation

7.6.1.6 The plan identifies documentation requirements, including any permits, licenses, or other regulatory requirements.

7.6.1.7 The plan includes labelling of hazardous materials and wastes.

7.6.2 There is a programme for the early detection and management of events caused by biological and chemical agents.

Standard Intent

The public health system must be able to respond to the deliberate release of biological and chemical agents. A Biological and Chemical Agent (BCA) plan is usually nationally or regionally based and must address early detection and containment of such events.

Each organisation will assess the relevance of their involvement in a Biological and Chemical Agents plan, and will assess this as a risk for exclusion or inclusion. The organisation has liaised with public or governmental entities to understand their expectations in this regard.

7.6.2 Criteria

7.6.2.1 One or more individuals oversee the infection, biologic and chemical agent control programme.

7.6.2.2 The individuals are qualified for the scope and complexity of the programme.

7.6.2.3 The Biologic and Chemical Agents (BCA) control programme is based on accepted practice guidelines.

7.6.2.4 The BCA control programme is based on applicable laws and regulations.

7.6.2.5 Information management systems support the BCA control programme.

7.6.2.6 All staff receive orientation to the organisation's BCA control procedures and practices.

7.6.2.7 All staff are educated in BCA control when new procedures are implemented.

7.6.2.8 All staff are educated in BCA control when significant trends are noted in surveillance data.

7.6.3 The organisation develops and implements a plan for response and mitigation of hazardous materials incidents.

7.6.3 Criteria

7.6.3.1 The organisation has a plan for responding to and mitigating hazardous materials incidents.

7.6.3.2 The plan addresses protocols for identifying potential and actual hazardous materials incidents.

7.6.3.3 The plan addresses defined roles and responsibilities for managing communications, triage, medical response, treatment, transport and hazardous substance(s).

7.6.3.4 The plan addresses protocols for identifying the hazardous substance(s).

7.6.3.5 The plan addresses criteria for responding to and containing the incident.

7.6.3.6 The plan addresses protocols for identifying, isolating and initiating early treatment of contaminated victims.

7.6.3.7 The plan addresses roles and responsibilities of other local and regional agencies that are involved in the hazardous materials response in order to ensure coordinated response.

7.6.4 The organisation develops and implements a plan that protects rescue staff and minimises their exposure to hazardous materials.

Standard Intent

Personnel responding to service requests may be exposed to hazardous materials, typically following motor vehicle accidents involving carriers. It is the responsibility of the leaders to make sure that staff is not exposed to personal risk when attending these incidents.

7.6.4 Criteria

7.6.4.1 The organisation identifies personnel tasked with hazardous materials duties.

7.6.4.2 The organisation provides the necessary equipment for the personnel as appropriate for their assigned duties.

7.6.4.3 The organisation provides the necessary training to personnel as appropriate for their assigned tasks.

7.6.4.4 Responding personnel have been trained to operate or appropriately use assigned equipment.

7.6.4.5 The organisation develops guidelines and criteria for hazardous materials personnel monitoring.

7.6.4.6 The organisation develops protocols for treatment of ill or injured hazardous materials personnel.

7.6.4.7 Rescue personnel are monitored during and after a hazardous materials incident.

7.6.4.8 The organisation keeps records of all exposure of personnel and/or volunteers to hazardous materials.

7.6.4.9 The organisation keeps records of all exposure of personnel and/or volunteers to hazardous materials.

7.7 Prevention and Control of Infections

7.7.1 As part of the risk management programme the organisation designs and implements a co-ordinated programme to reduce the risk of infections in patients and healthcare workers.

Standard Intent

For an infection prevention and control programme to be effective, it must be comprehensive, encompassing both patient care and employee health. The programme is appropriate to the size and geographic location of the organisation, the services offered by the organisation, and the patients seen by the organisation.

One or more individuals, acting on a full-time or part-time basis, direct the programme. Their qualifications depend on the activities they will carry out and may be met through education, training and experience. Co-ordination involves communication with all parts of the organisation to ensure that the programme is continuous and proactive.

Information is essential to an infection control programme. Information supports the tracking of risks, rates and trends in nosocomial infections, data analysis, interpretation and presentation of findings.

In addition, infection control programme data and information are managed with those of the organisation's quality management and improvement programme.

7.7.1 Criteria

7.7.1.1 An individual member of staff is identified to be responsible for infection control in the organisation.

7.7.1.2 All patient, staff and visitor areas of the organisation are included in the documented infection control programme.

The organisation identifies areas of risk e.g. contact centre staff headsets, vehicle radios etc. and addresses identified risks.

7.7.1.3 Disposal of infectious waste and body fluids is included in the programme.

7.7.1.4 Disposal of other clinical waste including sharps and needles is included in the programme.

7.7.1.5 The handling and disposal of blood and blood components are included in the programme.

7.7.1.6 Kitchen hygiene and food preparation and handling are included in the programme.

7.7.1.7 Written policies and procedures guide staff in the implementation of the infection control programme.

7.7.1.8 Regular in-service training to staff in the field of infection control is documented.

7.7.2 The organisation has a written plan for the handling, storage and disposal of waste.

Standard Intent

Regulated medical and infectious waste, are identified by the organisation and are safely controlled according to a plan. All clinical waste is regarded as hazardous or potentially hazardous.

7.7.2 Criteria

7.7.2.1 Waste is managed according to a written plan, consistent with current local by-laws and regulations.

The plan or policy meets or exceeds the criteria specified in the Waste Management Act (CAP 65.06). The organisation subcontracts such services, as applicable, to a service provider, who meets or exceeds CAP 65.06.

7.7.2.2 There is a colour coding system of bags to be used for the segregation of different types of waste.

7.7.2.3 The plan includes safe handling, storage and disposal of waste.

SE 8 QUALITY MANAGEMENT AND IMPROVEMENT

OVERVIEW OF QUALITY MANAGEMENT AND IMPROVEMENT

In order to initiate and maintain improvement, a formal quality improvement programme is required. This is most effective when it is planned and implemented on an organisation wide basis.

A formal quality improvement programme involves the accumulation of data regarding suitable measures (indicators), which are then analyzed. New processes are then designed and indicator data used to monitor the outcomes.

Standards

8.1 Quality Leadership and Direction

8.1.1 Those responsible for governing and leading the organisation participate in planning and monitoring a quality improvement programme.

8.1.1 Criteria

8.1.1.1 Those, who govern and lead, participate in planning and monitoring the quality management and improvement programme.

8.1.1.2 Medical direction participates to plan and carry out the quality management and improvement programme.

8.1.1.3 Managerial leaders participate to plan and carry out the quality management and improvement programme.

8.1.1.4 Both managerial and clinical staff closest to the activities being monitored, studied or improved participate in quality management and improvement activities.

*8.1.2 The leaders prioritise which processes should be monitored and which improvement activities should be carried out***.**

Standard Intent

Organizations typically find more opportunities for quality monitoring and improvement than they have human and other resources to accomplish. Therefore, the leaders provide focus for the organisation's quality monitoring and improvement activities. The leaders prioritize critical, high risk, problem-prone, primary processes that most directly relate to the quality of care and the safety of the environment. The leaders use available data and information to identify priority areas.

8.1.2 Criteria

8.1.2.1 The leaders set priorities for monitoring activities.

8.1.2.2 The leaders set priorities for improvement activities.

8.1.2.3 Managerial leaders implement quality monitoring systems, which address the transport and clinical services provided by the organisation.

8.1.2.4 Managerial leaders implement quality monitoring systems, which address patient satisfaction.

8.1.2.5 Managerial leaders implement quality monitoring systems, which address staff satisfaction.

8.1.2.6 Managerial leaders implement key performance indicators, which address the responsibilities of staff.

*8.1.3 The quality management and improvement programme is co-ordinated and programme information is communicated to staff***.**

Standard Intent

Available resources are used well when the quality management and improvement activities are centrally coordinated. This coordination is through a quality steering group or committee that provides effective oversight of quality management and improvement activities throughout the organisation. One of the responsibilities of such a coordinating group is to communicate information about the quality management and improvement programme to staff on a regular basis.

8.1.3 Criteria

8.1.3.2 The organisation's quality management and improvement programme is coordinated between management and all services.

8.1.3.3 Information on the programme is communicated to staff regularly.

8.1.3.4 There is a training programme for staff that is consistent with their role in the quality management and improvement programme.

SE 9 FACILITIES, EQUIPMENT AND VEHICLE MANAGEMENT

OVERVIEW OF FACILITY, EQUIPMENT AND VEHICLE MANAGEMENT

Laws, regulations and inspections by national governmental and local authorities determine in large part, how a facility is designed, used and maintained. All organisations, regardless of their size and resources, must comply with these requirements, as part of their responsibilities to their patients, families, staff and visitors. Organisations begin by complying with laws and regulations. Over time, they become more knowledgeable about the details of the physical facility they occupy. They begin to proactively gather data and carry out strategies to reduce risks and enhance the patient care environment.

Buildings, grounds, plant, machinery, vehicles and equipment are provided and maintained, and do not pose hazards to the occupants. Utility systems (electrical, water, oxygen, ventilation, vacuum and other utility systems) are maintained, to minimise the risks of operating failures.

Standards

9.1 Buildings, Plant, Installations and Machinery

9.1.1 Functional facilities are available to provide safety and comfort for staff.

Standard Intent

Laws, regulations and inspections by national government and local authorities determine in large part how a facility is designed, used and maintained. All organizations, regardless of size and resources, must comply with these requirements as part of their responsibilities to their staff and visitors.

Buildings, grounds, plant and machinery are provided and maintained, and do not pose hazards to the occupants. Utility systems (electrical, water, ventilation and other utility systems) are maintained to minimize the risks of operating failures. Ensuring that buildings, grounds, plant and machinery are provided and maintained requires that staff be knowledgeable and competent.

9.1.1 Criteria

9.1.1.1 The name of the facility and its purpose is clearly indicated on the site.

9.1.1.2 Staff facilities include adequate office space.

9.1.1.3 Staff facilities include a fire alarm system audible from each area of the staff quarters.

9.1.1.4 Staff facilities include alarms for security threats.

9.1.1.5 Staff facilities include separate toilet/washroom facility

9.1.1.6 Staff facilities include at least staff restroom/cloakroom, with adequate secure storage facilities for staff outdoor clothing, handbags and personal possessions.

9.1.1.7 Staff facilities include at least training rooms and equipment, where indicated.

9.1.1.8 Staff facilities include at least socialisation area, where indicated.

9.1.1.9 Staff facilities include at least outdoor areas, where indicated.

9.1.1.10 Staff facilities include at least adequate, suitably furnished, kitchen and dining rooms, where indicated.

9.1.1.11 Staff facilities include at least sufficient recreational equipment, Where indicated.

9.1.2 The organisation plans and implements a programme to manage the physical environment.

9.1.2 Criteria

9.1.2.1 The organisation has a programme to manage the physical facility.

9.1.2.2 The programme is effective in preventing injury and maintaining safe operating and working conditions.

9.1.2.3 The programme includes safety, security and hazardous materials.

9.1.2.4 The organisation has a documented, current, accurate inspection of its physical facilities.

9.1.2.5 The organisation has a plan to reduce evident risks based on the inspection.

9.1.3 The organisation complies with relevant laws, regulations, vehicle, equipment and facility inspection requirements.

9.1.3 Criteria

9.1.3.1 The organisation's leaders are responsible for ensuring compliance with laws, regulations and other requirements applicable to the organisation's facilities, equipment and vehicles.

9.1.3.2 The organisation has a programme to manage its vehicle fleet.

9.1.3.3 The leaders ensure that the organisation meets the conditions of facility inspection reports, periodic equipment review, vehicle maintenance records or citations.

9.1.3.4 The organisation plans and budgets to meet applicable laws, regulations and other requirements.

9.1.3.5 The organisation plans and budgets for the upgrading or replacing of systems, buildings or components needed for the continued safe and effective operation of facilities equipment and vehicles.

9.2 Communication Systems

9.2.1 The facility has been provided with reliable communication systems.

9.2.1 Criteria

9.2.1.1 Each facility where emergency medical (ambulance) services (EMS) are provided has a reliable telephone connection (down time less than 48 hours) and back up is provided by 2 way radio and/or cell phone.

9.2.1.2 Each facility where EMS services are provided has access to a fax machine.

9.2.1.3 EMS services are adequately supported by computer access and networking systems.

9.3 Vehicle Management

9.3.1 The use of organisational motor vehicles by staff is planned and monitored to ensure safety and legality.

Standard Intent

The use of vehicles needs to be controlled because of the cost of acquiring and maintaining vehicles, and legal aspects relating to the driving of vehicles and transport of passengers.

The Road Traffic Act does not provide for exemption from laws for ambulances, or any guidelines for such. Nor is there any legislation defining what an "ambulance" or Rapid Response Vehicle is.

9.3.1 Criteria

9.3.1.1 A specific manager is identified for the control, use and maintenance of vehicles.

9.3.1.2 The need for the use of transport is established by management in consultation with the users of vehicles and is reviewed annually.

9.3.1.3 There is a system for monitoring the use of vehicles (permission, records).

9.3.1.4 There is a system for booking of vehicles in advance.

9.3.1.5 There is a control system for mileage travelled.

9.3.1.6 Drivers of vehicles are suitably licensed.

9.3.1.7 Vehicles are suitably licensed.

9.3.2 The organisation provides policies and procedures for the cleaning of vehicles.

9.3.2 Criteria

9.3.2.1 Policies and procedures include the sites at which vehicles may be cleaned.

9.3.2.2 Policies and procedures specify that vehicles may only be cleaned at purpose designed wash-bays with appropriate filters to prevent environmental contamination.

*The purpose built wash-bays have filters in the drainage openings to catch items that need to be disposed of according to infection prevention and control methods i.e. to prevent potentially dangerous materials from entering the ordinary waste water/sewage system. However, it may be prohibitive to source and finance redesign of these to dispose of any **possible** infective substances e.g. rinsing out blood/bodily fluids.*

9.3.2.3 The organisation budgets for the provision of appropriate wash facilities.

9.3.2.4 Policies and procedures specify what cleaning methods and chemicals must be used for cleaning vehicles.

9.3.2.5 Policies and procedures address the training of personnel in proper cleaning methods.

9.3.2.6 Vehicles are clean and in working order when in use.

9.3.3 The organisation maintains and inspects its transport fleet to reduce risk and provide safe vehicles.

9.3.3 Criteria

9.3.3.1 There is a vehicle maintenance programme.

9.3.3.2 The programme includes the tracking of vehicle failures.

9.3.3.3 The programme is effective in preventing injury and maintaining Safe vehicles.

9.3.3.4 There is proof of vehicle maintenance.

9.3.3.5 The organisation has a documented, current, accurate inspection of its transport and other vehicles.

9.3.3.6 The organisation implements processes to reduce evident risks based on the inspection.

9.4 Medical Equipment

9.4.1 The organisation plans and implements a programme for inspecting, testing and maintaining equipment.

9.4.1 Criteria

9.4.1.1 Equipment is managed throughout the organisation according to a plan.

9.4.1.2 There is an inventory or asset register of all equipment.

9.4.1.3 Equipment is regularly inspected.

9.4.1.4 Equipment is tested when new and as appropriate thereafter.

9.4.1.5 There is a process in place to retrieve equipment from facilities where patients have been delivered.

9.4.1.6 There is a preventive maintenance programme.

9.4.1.7 Qualified individuals provide these services.

The individuals, or subcontracted entities, used to provide these services are certified to conduct such maintenance appropriate to the type of equipment being maintained.

9.4.1.8 Monitoring data are collected and documented for the equipment and communication equipment.

9.4.1.9 Monitoring data are used for purposes of planning and improvement.

SE 10 PATIENT CARE

OVERVIEW OF PATIENT CARE

A health organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and co-ordination.

Certain activities are basic to patient care, including planning and delivering care to each patient, monitoring the patient to understand the results of the care, modifying care when necessary and completing the follow-up.

A plan for each patient is based on an assessment of needs. A plan of care is not sufficient to achieve optimal outcomes unless the delivery of the services is co-ordinated, integrated and monitored.

Continuity of Care
Several departments, services and different healthcare providers may be involved in providing care. Throughout all phases of care, patient needs are matched with appropriate resources within and, when necessary, outside the organisation. Processes for continuity and co-ordination of care must be implemented in and between all services.

Leaders of various settings and services work together to design and implement the required processes to ensure co-ordination of care.

Standards

10.1 Assessment Process

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

10.1.1 Criteria

10.1.1.1 Organisation policy and procedure define the information to be obtained for different types of patients.

10.1.1.2 Priority categories are defined.

10.1.1.3 The patient is assessed in accordance with the relevant patient report form.

10.1.1.4 Assessment findings are documented in the patient's record.

10.1.1.5 The initial assessment results in selecting the best setting and destination for the care (for example, burn unit or trauma unit).

10.1.2 All patients are reassessed at appropriate intervals to determine their response to treatment and to plan for continued treatment or release.

10.1.2 Criteria

10.1.2.1 Only those individuals permitted by licensure, applicable laws and regulations, or certification, perform the assessments.

This refers to the Botswana Health Professions Council role in defining Scope of Practice and Clinical Practice Guidelines.

10.1.2.2 Patients are reassessed to determine their response to treatment.

10.1.2.3 Patients are reassessed at intervals appropriate to their condition.

10.1.2.4 Reassessments are documented in the patient's record.

10.2 Point of Care Testing

10.2.1 The medical transport organisation identifies any point of care (POC) testing that will be conducted, and the extent to which such test results are used in patient care (definitive or used only as a screen).

Standard Intent

This standard refers to biochemical or haematological assessment which takes place outside the laboratory, for example glucose or haemoglobin testing.

10.2.1 Criteria

10.2.1.1 The organisation identifies any point of care tests to be conducted.

10.2.1.2 The organisation identifies how the results will be used.

10.2.1.3 Staff have had specific training in the tests they perform.

10.2.1.4 Staff are oriented to the tests performed by the organisation.

10.2.1.5 Staff have shown current competence in performing tests.

10.2.1.6 Staff skills are assessed at defined intervals.

10.3 Delivery of Care for All Patients

10.3.1 Policies and procedures and applicable laws and regulations guide the uniform care of all patients.

10.3.1 Criteria

10.3.1.1 Policies and procedures guide uniform care and reflect relevant laws and regulations.

10.3.1.2 Response times are monitored, using single or regularly synchronised clocks.

10.3.1.3 There is a process to communicate patient assessments and other clinical data to hospital providers.

10.3.2 Care is planned and documented in the patient's record.

10.3.2 Criteria

10.3.2.1 The care of each patient is planned.

10.3.2.2 The patient's plan of care is modified as the patient's needs change.

10.3.2.3 The care is documented in the patient's record.

10.3.2.4 The interventions performed are entered in the patient's record.

10.4 Sedation and Induced Paralysis

10.4.1 Sedation is provided by qualified individuals.

10.4.1 Criteria

10.4.1.1 Individuals administering, or causing, sedation are trained to monitor patients carefully in order to maintain them at the desired level of sedation.

Linked standards:
2.4.1 and 2.4.2

10.4.1.2 Individuals administering, or causing, sedation can demonstrate competence in the use of sedation and resuscitation equipment and monitoring vital signs (including heart and respiratory rates, pulse-oximetry [for all but minimal sedation], and blood pressure).

Linked standards:
2.4.1 and 2.4.2

10.4.1.3 Sedative care provided to each patient is recorded in the patient's clinical record.

10.4.2 Each patient's physiological status is monitored during and following administration of sedation.

10.4.2 Criteria

10.4.2.1 Appropriate equipment for care and resuscitation is available for monitoring vital signs, including heart rate and rhythm, respiratory rate, capnography, and/or pulse oximetry.

10.4.2.2 Heart rate and rhythm and pulse oximetry (for all but minimal sedation) are continuously monitored.

10.4.2.3 Respiratory frequency and adequacy of pulmonary ventilation are continually monitored.

10.4.2.4 Blood pressure is measured in accordance with guidelines.

10.4.2.5 The results of monitoring are documented.

10.5 Invasive Procedures

10.5.1 Invasive procedures are based on the results of a patient's assessment.

10.5.1 Criteria

10.5.1.1 Patient assessment information is the basis for determining the need for invasive procedures.

10.5.1.2 The patient's diagnosis is recorded in the patient's record.

10.5.1.3 A description of the invasive procedure and any findings is recorded.

10.5.1.4 The names of those performing or assisting the procedure are recorded.

10.5.2 Each patient's physiological status is continuously monitored during and immediately after the invasive procedure and written in the patient's record.

10.5.2 Criteria

10.5.2.1 The patient's physiological status is monitored appropriately during the procedure.

10.5.2.2 The patient's physiological status is monitored during the immediate post-procedure period.

10.5.2.3 Findings are entered into the patient's record.

10.5.2.4 Each patient's post-procedure care is planned.

10.5.2.5 The care provided is documented in the patient's record.

10.6 Medication Use

10.6.1 Medications are properly stored, used and recalled when appropriate.

10.6.1 Criteria

10.6.1.1 Medications are protected from loss, theft or damage.

10.6.1.2 Medication use complies with applicable laws and regulations.

10.6.1.3 Only those permitted by the organisation and by relevant licensure, laws and regulations prescribe and administer medications.

10.6.1.4 Medications are labelled properly.

10.6.1.5 Medication storage complies with laws, regulations and professional standards of practice.

10.6.1.6 There is a medication recall system in place.

10.6.1.7 Policies and procedures address any use of any known expired or out- dated medications.

10.6.1.8 Policies and procedures address the destruction of any know expired or out-dated medications.

10.6.1.9 Policies and procedures are implemented.

10.6.2 Medication effects on patients are monitored.

10.6.2 Criteria

10.6.2.1 Medications prescribed and administered are written in the patient's record.

10.6.2.2 Medication administration is recorded for each dose.

10.6.2.3 Monitoring includes observing adverse medication effects.

10.6.2.4 Adverse effects are documented in the patient's record.

10.6.2.5 Adverse effects are reported as required.

10.7 Non-Treatment and Non-Transport

10.7.1 There is a process to treat and release patients.

10.7.1 Criteria

10.7.1.1 There is a process to treat and release patients.

10.7.1.2 The process addresses verification of the patient's mental competency.

10.7.1.3 The process addresses criteria for transporting a patient against his or her will.

10.7.1.4 The organisation informs patients about the consequences of their decisions.

10.7.1.5 The organisation informs patients and families about their responsibilities related to such decisions.

10.7.1.6 Written criteria are used to determine when the medical transport provider can decline to treat or transport a patient.

10.7.1.7 When the medical transport provider decides not to treat or transport a patient, there is a process to ensure that the patient is physically and clinically safe.

10.7.1.8 Personnel are trained in all protocols and can verbalise the process to follow when these situations arise.