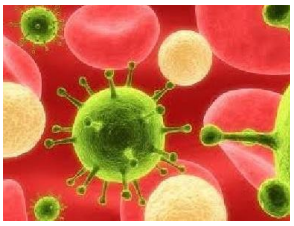
SERHA

Clinical Audit Report

Secondary Care Facilities in South East Regional Health Authority



This report covers the High Risk MONIA Clinical Service Delivery Areas in the major hospitals

Regional Technical Department

July 2015

LIST OF ABBREVIATIONS

A&E	Accident and Emergency Department
BHC	Bustamante Hospital for Children
CSSD	Central Sterile Supply Department
FCU	Fertility Control Unit
IC	Infection Control
KPH	Kingston Public Hospital
MOH	Ministry of Health
MONIA	Maternity/Obstetrics, Operating Theatre, Neonatal Unit, Intensive Care Unit, Accident and Emergency Department
NCH	National Chest Hospital
NPHL	National Public Health Laboratory

OT	Operating Theatre
PMH	Princess Margaret Hospital
SERHA	South East Regional Health Authority
SOP	Standard Operating Plan
STH	Spanish Town Hospital
VJH	Victoria Jubilee Hospital

MONIA AUDIT

This report outlines the audit findings from the High Risk Clinical S e r v i c e Delivery Areas in the major SERHA hospitals

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EXECUTIVE SUMMARY

An infection control audit is an opportunity to implement changes and to introduce remedial measures in collaboration with various departments and services. A standardized approach to the audit allows benchmarking of practices across the institutions and enhances standards of care.

A number of observations were common to all the hospitals:

1) Structurally, the operating Theatre suites were built many years ago and hence the layout of the operating rooms, sluice rooms, recovery rooms etc are not ideal.
However, in some instances the layout needs a review, and if possible changes implemented to facilitate patient, staff and supplies flows e.g. at BHC sterile supplies and instruments have to be taken through the ñdirtyò sluice room to get to an operating ñcleanñ area.

   In addition, the demarcation of access areas for traffic flow through the theatre suite is non-existent. As such, there is difficulty ascertaining the levels of restriction. The Theatre doors at the majority of facilities need urgent replacement. It is quite easy to see through the space between the doors when they are ñclosedò, compromising sterility in the rooms. Some doors have holes, hinges are rusted and others are infested with termites. Subjectively, the operating theatre lights are dull and some fixtures have absent and non- functional bulbs. In general, the operating theatre suites need to be assessed by the engineers to check on structural integrity.

2) The preparation of the cleaning and sterilising solutions is too individualised. The requirements for mixing and the required concentrations are not documented hence the level of cleanliness achieved after cleaning is questionable. Ideally, there should be standardisation of the types of solutions/ agents to be used for cleaning, sterilisation and hand-washing. The decision on the compounds to be used should require the input of the Medical Microbiologist at the National Public Health Laboratory. The materials safety sheet needs to be made available to staff.

3) The Janitorial Staff generally, are not provided with utility gloves as required and the buckets and mops provided by the contractors are inadequate in quantity and quality. The Contracts Monitoring Officer in each institution needs to have a monitoring schedule for the cleaning activities and document the findings.

4) Training for the Janitorial Staff throughout the system is essential if infection prevention and control standards are to be adhered to and be properly managed.

5) The SOPs developed by the RHA for Cleaning and Portering were not seen in any of the institutions visited.

6) Bacteriological swabbing of the clinical units on a regular schedule needs to be institutionalised. Currently, there is a disconnect between the hospitals and the National Public Health Laboratory on the matter of the receiving and processing of these swabs. A meeting with the Director of the NPHL is necessary.

7) It was noted that the reuse of disposable tubes and airways was a common feature throughout the region. While it is recognised that this is a cost saving measure it must be acknowledged that chemicals will disrupt the surface of the plastic tubing and create pockets for organisms to attach and multiply. A number of these items were seen hanging to be dried after "cleaning" and then just placed unwrapped in drawers or hung on hooks.

8) There was a general lack of the appropriate containers for the disposal of sharps and an apparent shortfall in the provision of correctly coloured bags for the storage and disposal of waste. This compromises staff and patient safety.

9) Maternity/ Obstetrics Units are extremely short of small items of equipment particularly for the delivery process e.g. thermometers, forceps, foetal stethoscopes, episiotomy scissors, kockers forceps, cord clamps and large kidney dishes.

10) Linen and gowns are also in short supply.

11) Enema is no longer provided by the pharmacies hence women are delivered without; the result being foul odour in the delivery room, staff health being affected and possible infection of the neonates.

12) The provision of lavatory facilities for patients and their relatives is imperative therefore a process must be found to protect the facilities from vandalism and soap, tissue and hand towels or a hand drier are necessary. In some institutions toilets had no seats, soap or a hand drying method available.

13) Fire drills, disaster and emergency simulations were noted to be absent. Staff need to be familiarised with these procedures in order to prevent mayhem and unnecessary deaths in the event of a disaster.

14) There are clinical meetings and category meetings but there was no evidence that general staff meetings are being held. Communication and the sharing of information enhance team-work and promote identification with an institution. These should be mandated

15) The Client Complaint mechanism is not well known by the majority of staff. There needs to be in-house sensitisation sessions at the institutions. The practice in most places is to send the complainants to the Patient Affairs Departments.

16) The orientation process for recruited staff needs to be formalised. The orientation should include both administrative and clinical staff.

17) The MOH manuals for Infection prevention and control and for the Accident and Emergency Departments are in short supply and therefore not easily accessible. Additional copies need to be produced.

18) The National Health Fund's supply of drugs and particularly antibiotics needs to be reviewed as the majority of facilities are experiencing critical shortages. This is currently compromising patient care.

INTRODUCTION

The purpose of an Infection Control programme is to prevent the spread of communicable diseases within a health facility or a community. Monitoring and Surveillance are required to ensure infection control procedures are followed and are effective throughout a health facility, on a regular and on-going basis, through a series of audits and quality control activities;

The **MONIA Risk Management Framework** targets **six areas** in the **hospita**l for improvement of **clinical quality.** These are:-

- **M**aternity / Obstetrics
- **O**perating Theatre
- **N**eonatology Unit
- **I**ntensive Care Unit
- **A**ccident and Emergency Department

RATIONALE AND PURPOSE

The clinical audit was conducted following a directive from the Chairman of the South East Regional Health Authority Board.

An audit is an organized examination of ward or service practices and procedures that provides an opportunity to simultaneously review safety in the workplace, promote infection prevention and control improvement activities in partnership with an organization's multidisciplinary teams and identify and remedy deficiencies

BACKGROUND

The South East Regional Health Authority (SERHA) is a statutory body of the Ministry of Health. SERHA is one of four Regional Health Authorities formed as a part of the Health Sector reform programme, by passage of the National Health Services Act in 1997.

SERHA is responsible for the delivery of health care services to the residents of St. Catherine, St. Thomas, Kingston and St. Andrew. This represents 47% of the population of Jamaica.

Health Care is delivered through a network of 9 hospitals and 89 Health Centres. Five of the nine hospitals within the region are also specialist or National Referral Hospitals. Some of these institutions also accept patients referred from other Caribbean islands.

The Hospitals and areas audited were:

Hospital	High Risk Areas
Spanish Town (STH)	Maternity, A&E , Operating Theatre Suite
Kingston Public (KPH)	A&E, Intensive Care unit, Operating Theatre Suite
Princess Margaret (PMH)	Maternity, A&E, Operating Theatre Suite
Bustamante (BHC)	A&E, Neonatal Nursery, Intensive care Unit, Operating Theatre Suite
Victoria Jubilee (VJH)	Maternity, Operating theatre Suite
National Chest (NCH)	Operating Theatre Suite

METHODOLOGY

The audit team consisted of a multidisciplinary mix of technical personnel from the Regional Health Authority and the field. Prior to the commencement of each audit an opening meeting was held with relevant senior staff of the institutions to review the audit process and allay fears.

The audits were conducted using the audit instruments from the Ministry of Healthôs Policies and Procedures Manual for High Risk clinical areas, focusing on the general management of the service areas and infection prevention and control.

During the audits documents were reviewed and observational tours of the physical plant were carried out. In addition an assessment was done of the knowledge and application of infection control principles of the staff through discussions.

On completion of the audits a closing meeting was held with staff, audit findings discussed and feedback received from the staff.

AUDIT FINDINGS

SPANISH TOWN HOSPTAL

The Spanish Town Hospital is located in the parish of St. Catherine, the fastest growing parish in the island and continues to experience an increasing demand on its services as it serves rapidly growing communities in St. Catherine such as Portmore, Eltham, Angels Estate and Ensom City. Also, its close proximity to three major highways contributes to an increasing number of victims of motor vehicle accidents accessing the hospital for Emergency Medical Care.

It is the largest Type B Hospital in the island and has statistics comparable to Kingston Public Hospital, Cornwall Regional Hospital, the islandôs only two type óAô hospitals.

The service areas audited were the Neonatal Nursery, Accident and Emergency Department, Intensive Care Unit and the Operating Theatre Suite.

NON-CONFORMANCES

Accident and Emergency Department

a) Hand-washing guidelines are not being adhered to. Blood is taken without gloves and hands are not washed after removing gloves.

b) Cleaning materials are not labelled.

c) There is no documented cleaning schedule.

d) The cleaning methods do not conform to standards.

e) Job descriptions are to be prepared and given to all staff on recruitment.

f) Staff needs to be made familiar with the mass casualty plan and the plan should be tested at least once per year.

g) Wheelchairs and stretchers are in short supply. Patients who are awaiting admission to the wards stay on the chairs and stretchers for extended periods.

h) Additional wheel-chairs are needed in the department. A number of wheelchairs are defective with no rubber on the wheels and no footrests.

i) Additional stretchers are needed in the department.

j) Sharps containers are inappropriate. Cardboard boxes and plastic bottles are used.

k) Patient bathrooms need to be upgraded. Seats and tank covers were missing in a few places. The staff toilet in the records department did not flush.

l) Orientation guidelines need to be prepared for clinical staff.

m) No log books are being used. Sheets of paper are used for triaging and these are put in the patient records. Therefore no record remains in the department.

n) A system is needed for the monitoring of the usage of drugs and supplies, in order to prevent stock-outs.

o) Clinical practice guidelines for commonly seen conditions are necessary in order to standardize the emergency care given.

Maternity/ Obstetrics Unit

a) Mothers are not assigned identification tags.
b) The delivery beds are not the appropriate beds.
c) Inappropriate Sharps containers are being used.
d) Staff does not wear identification badges.
e) Discharge summaries remain delayed in completion.
f) Orientation guidelines need to be prepared for the clinical staff
g) A number of items are in short supply or are absent viz.
   - Sphygmomanometers and stethoscopes
   - Thermometers Fleet enema
   - Facilities for sitz baths

Neonatal Nursery

a) The containers with the cleaning agents are not labelled.
b) The cleaning methods do not conform to standards and schedules are not documented.
c) Makeshift sharps containers are being used. These present a risk to staff.
d) The store room has a number of non-functional pieces of equipment. These need to be removed so that the spare beds for the nursery can be stored there instead of in a space on the nursery ward.
e) Excess furniture in the clinical area hampers the proper cleaning of the floor.
f) Food and drugs are stored in the same refrigerator. This affects the cold ï chain management of the drugs. A refrigerator is needed to store the food and drink belonging to staff.
g) Hand-towels are in short supply hence expensive gauze is being cut for hand drying. This is ñpennywise and pound foolishò.
h) On the day of the audit a Gram-negative organism outbreak was reported in the nursery and there was said to be an absence of the appropriate antibiotics required for the treatment of the babies.

Operating Theatre Suite (Main)

a) The tiles on the walls do not allow for adequate cleaning.
b) The Operating room is crowded with boxes, supplies and unused equipment. These all hamper proper cleaning of the area.
c) The operating lights are dull in intensity.
d) There is ñfungusò growing between the panes of glass in the window of the operating room.
e) There is no documented cleaning schedule or documented evidence of monitoring of the cleaning activities.
f) The storage areas are without doors and are scattered in different areas of the Operating suite.
g) The delineation of the access areas needs to be made clear. Infection control is being compromised.
h) The disposal of waste from the theatres requires an urgent review and re-organisation. Bins with dirty linen etc are left in the sluice room overnight and removed in the morning through the operating theatre.
i) The segregation of linen needs to be implemented. Soiled linen is put in the open bin with dry dirty linen and the correct colour coded bags are necessary.
j) The expiry date is not affixed to the sterile packs. The date of sterilisation is used. This is not the policy.
k) There is no logbook for supplies sent to the CSSD.
l) The opening of the unused chimney in the roof of the sterile room needs to be closed off.
m) The carbolic soap being used for hand scrubbing needs to be removed if the antimicrobials are now to be used.
n) Material safety sheets for the disinfectants need to be made available to the staff.
o) Janitorial staff require training in the correct methods of cleaning and the materials and concentrations of chemicals to be used.
p) The mops being used are not of the required standard and the number of mops and buckets provided are inadequate.
q) The workload in the theatre is enough to warrant the assignment of a secretary/ records officer.

KINGSTON PUBLIC HOSPITAL

The Kingston Public Hospital is the largest multidisciplinary hospital in the Government Health Service as well as the largest trauma centre in the public hospital system. The hospital has a bed capacity of five hundred (500) and offers a wide range of specialist diagnostic and rehabilitative services, as well as curative services in medicine, surgery and related sub-specialties.

The areas audited were the Accident and Emergency Department, Intensive Care Unit and Operating Theatre Suite.

NON-CONFORMANCES

Accident and Emergency Department

Overall the A&E department appeared to be clean, well-organized and non-cluttered.

a) The containers with the cleaning agents are not labelled.
b) The cleaning methods do not conform to standards and schedules are not documented.
c) Job descriptions are to be prepared and given to all staff on recruitment.
d) Staff need to be made familiar with the mass casualty plan and the plan should be tested at least once per year.
e) Additional wheel-chairs are needed in the department as patients sent to the wards for admission tend to remain in the wheelchairs until a bed is allocated. Effectively reducing the wheelchairs available for use in the A&E department.
f) Additional stretchers are also needed in the department.
g) The patient lavatories lack seats, toilet tissue and hand-drying facilities. It was reported that the toilets tend to be damaged by the patients. As such a system of securing the facilities needs to be implemented, while ensuring Infection prevention and control is maintained.
h) A system is needed for the monitoring of the usage of drugs and supplies, in order to prevent stock-outs
i) The development of a portering procedure manual and training are essential to ensure the safe transportation and handling of patients.
j) Clinical practice guidelines for commonly seen conditions are necessary in order to standardize the emergency care given.
k) Death review meetings and quarterly internal audits need to be institutionalized.

Intensive Care Unit

a) The blood gas machine is non-functional.
b) Transducers are required for the monitors.

c) Hand-washing is not enforced. Hand sanitizer is rarely being used and there are no hand-washing guidelines above the stations.

d) The Microbiologist does not visit for regular checks to review the microbial profile and therapy with staff.

e) Containers for the collection of trapped sputum are absent. There are no containers available.

f) Additional examination lamps are required.

Operating Theatre Suite

a) The Operating Theatre (OT) doors all need to be repaired or replaced.
b) The light in Operating Theatre 1 is pale, while there are missing bulbs for the one in Operating Theatre 2. The light in Operating Theatre 3 is in need of repairs.
c) Hand washing reminders are required.
d) The CENTRAL AIR CONDITIONING UNIT is out of service and THE SPLIT AIR CONDITIONING UNITS fluctuate in function.
e) Cracks in the floor of the Operating Rooms may lead to breaches in infection control.
f) Ceiling tiles in the scrub areas are discoloured or missing.

PRINCESS MARGARET HOSPITAL

The Princess Margaret Hospital is classified as a Type C hospital. It is the only hospital in the parish of St. Thomas and serves a population of approximately 120,000.00 people. The Princess Margaret Hospital also offers services to neighbouring areas as far as Eastern Portland and Eastern St. Andrew.

The areas audited were the Accident and Emergency Department, Operating Theatre Suite and Maternity/Obstetric Unit.

NON-CONFORMANCES

Accident and Emergency Department

a) The cleaning of the patient bathrooms needs to be more closely monitored.

b) There is no cleaning schedule available.

c) Incorrectly coloured bags are used for the disposal of the different categories of waste. This has implications for staff safety.

d) No list for the inventory of equipment was available.

e) Documentation in the patient records was not in keeping with the required standards.

f) Cards are being used to record patient information.

g) The orientation of staff is not structured.

h) Quarterly staff meetings are held but it is not mandatory for all staff to attend.

i) Customer service personnel are in place but there is no system to advise patients that this service is available.

j) There is no space available for the counselling of relatives of critically ill patients. This is done in the open area.

k) There is no Quality Assurance Committee.

l) Protocols in existence are not communicated to staff.

Operating Theatre Suite

a) The recovery room has no RECOVERY ROOM beds. Stretchers are used. This is not suitable for post-operative care.
b) The anaesthetic machine in one of the Operating Rooms is not working.
c) Patient monitors are not functioning.
d) The Operating Theatre (OT) doors all need to be repaired or replaced.
e) The theatre light has missing bulbs and its suspension is faulty making focusing difficult
f) The transportation of waste from the Sluice Room needs to be reverted to the original process of using the stairs at the back of the OT.
g) Hand washing reminders are required.
h) The CENTRAL AIR CONDITIONING UNIT is out of service and the SPLIT AIR CONDITIONING UNITS fluctuate in function.
i) Cracks in the floor of the Operating Room limit intensive cleaning as the water affects the laboratory beneath
j) The water pipe runs along the cove of one of the ORS. This limits proper infection control.
k) No BATHROOM is in the Operating Theatre area for the patients.
l) The changing room for patients is inadequate and inappropriate.

Maternity/ Obstetrics Unit

a) No cleaning schedule was documented.
b) The delivery beds are not the ideal beds.
c) Stethoscopes and sphygmomanometers are not available.
d) The partograph is not being used as per policy.
e) Patients are not given identification tags.
f) The system for security needs to be reviewed.

BUSTAMANTE HOSPITAL for CHILDREN

The Bustamante Hospital for Children provides medical, surgical, specialist and diagnostic services for children up to 12 years of age. The Hospital has a bed capacity of 283 including a 5 bed Intensive Care Unit that provides critical care service to critically ill patients.

The areas audited were the Neonatal Nursery, Accident and Emergency Department, Intensive Care Unit and Operating Theatre Suite.

NON-CONFORMANCES

Accident and Emergency Department

Patientôs lavatories are immaculate

a) Cleaning procedures and methods are not in accordance with standards.
b) Chemicals are not labelled and need to be stored away from the children.
c) Medical records are not being completed according to standards.

Intensive Care Unit

a) The central AC unit is defunct. 3 split units are being used.
b) There is no ICU Policy and Procedures Manual available within the unit.
c) There are no dedicated ICU beds. The beds from the wards are being used. These however are not able to be tilted and have the necessary changeable positions for efficient patient care and resuscitation.
d) The storage area is congested with the same room serving for counselling, lunch room, overnight room, meetings and storage.
e) There is no changing room or shower for staff.
f) Lockers are needed for staff to keep their personal items.
g) Containers for the collection of trapped sputum are not available.
h) Monitors are old and at times unreliable.
i) Additional back-up ventilators are needed.

Operating Theatre Suite

a) Access areas are not clearly delineated.
b) Cabinets for the storage of sterile supplies etc are door-less, in different stages of disrepair and scattered in various parts of the O.T suite.
c) The main storage room is disorganised. This does not facilitate any form of inventory control or the rotation of items to prevent wastage due to items becoming outdated.
d) A cleaning schedule is to be developed and documented with clear SOPs for the janitorial staff and Patient Care Assistants. There is too much individualisation in the preparation of cleaning solutions.
e) A monitoring schedule for the assessment of Infection control practices is to be prepared.
f) Janitorial staff are not provided with utility gloves and mops of the appropriate quality or quantity.
g) The OT doors are in a poor state. Hinges are rusted and functioning poorly, windows are broken and some have termites. The majority of theatre doors are unable to be properly closed.
h) Sterile items are being passed through the sluice room. This is unacceptable.
i) The janitorial staff assigned to the operating theatre requires training in the proper use of the cleaning materials.
j) There is need for the overall standardisation of the cleaning and disinfecting solutions to be used in the high risk areas.
k) There is no monitoring of the health or immunisation status of staff working in the OT suite.
l) The recovery room has a leaking roof.

VICTORIA JUBILEE HOSPITAL

The Victoria Jubilee Hospital is the largest referral maternity hospital in the English Speaking Caribbean. It provides obstetric and gynaecological care for women island-wide. Victoria Jubilee Hospital sees more than 70,000 women and approximately 8,000 babies are delivered each year. The institution has a bed capacity of 248. Forty percent of the hospitalôs out-patients are from the inner city communities which surround the hospital.

The areas audited were the Operating Theatre Suite, Fertility Control Unit (FCU), Neonatal Nursery and Maternity/Obstetric Unit.

NON-CONFORMANCES

Operating Theatre Suite

a) There is a shortage of theatre clothes in the FCU theatre.
b) The bathrooms in the FCU need urgent attention. Nursing staff and patients are using the same facilities in the FCU.
c) Storage of sterile supplies is in uncovered areas. In addition a trolley is used for additional storage.
d) There is no specific assignment of personnel to assessing the adherence to infection control practices.
e) The access areas are not clearly identified. Hence traffic flow is not monitored or restricted as it should be.
f) Anaesthetists are resisting the wearing of facial masks in the operating room
g) The janitorial staff all need to be given training on the proper mixing and use of the cleaning materials
h) The timely removal of waste from the outer corridors needs to be organised to be in tandem with the heavy patient load.
i) Contractors have not provided utility gloves for the janitors.
j) Instruments are being soaked in antiseptic solutions out of keeping with the standard.
k) The health and immunisation status of the staff are to be monitored according to the recommended schedule.

Maternity/Obstetrics Unit

a) The cleaning materials and methods do not conform to the MOH standards
b) The labour and delivery suite need to have dedicated janitors- there are confidentiality and privacy issues.
c) More oxygen cylinders are required for the wards and the cylinders that exist need to be anchored to prevent injury to staff and patients in the event of a mishap.
d) There is one Resuscitaire in the delivery room. On occasions more than one child has to be on the tray.
e) There is one Foetal monitor which has to be shared by mothers in the first stage room.
f) There is one pulse-oximeter for the entire Labour and Delivery suite.
g) Adequate wheelchairs are in the labour and delivery suite but there are no dedicated stretchers.
h) New delivery beds have been acquired however the upper 2/3rds of these beds have mattresses which are fixed and therefore are unable to be adequately cleaned. Macintoshes are required to cover and protect these new beds.
i) There are no permanent screens in the first stage room and in a case where a delivery is imminent there is no possibility of privacy. Addition mobile screens are necessary.
j) There are no emergency buzzers or any form of communication for the patients to alert the clinical staff. ñShoutingò is the mode of alert.
k) The sluice room is in a terrible condition. The sink is inappropriate, the ceiling is non- existent, and the whole room is grimy. Urgent refurbishment is necessary.
l) Buckets are being used as Sharps containers.
m) Fire drills are not being done. A number of areas have fire extinguishers.
n) There are a number of small items of equipment and supplies which are in short supply:
    i) Kidney dishes, forceps
    ii) Foetal stethoscopes, kockers forceps
    iii) Cord scissors, cord clamps
    iv) Thermometers, episiotomy scissors
    v) Supplies of enema
    vi) Linen

Neonatal Nursery

a) There is no cleaning schedule available.
b) The cleaning materials and methods do not conform to the MOH standards
c) There was no copy of the Health Facility Infection prevention and Control Manual.
d) The inventory for the equipment is kept solely by the maintenance unit.
e) There is no system to monitor the usage pattern of essential drugs and supplies.

This is important in order to facilitate supplies management.

f) There is no auditing process in place.
g) Staff are unaware of the Client Complaint Mechanism.
h) No death review meetings are held.
i) There is a shortage of sharps containers
j) The Resuscitaire is defective. One side is absent which may result in a child falling to the floor.
k) There is one physiological monitor for the entire unit.
l) There are three suction machines ï none are functional. One portable unit is being shared among babies.
m) The fire exit needs a ramp to facilitate the easy removal of cots and equipment in an emergency. Currently there is only the stairway.

NATIONAL CHEST HOSPITAL

The National Chest Hospital operates with a compliment of 90 beds and is the islandôs only specialist hospital in cardio-thoracic care, treating conditions affecting the lungs, heart and other structures of the chest. These include respiratory diseases such as asthma and pneumonia. The hospital sees over 3,000 patients annually.

The area audited was the Operating Theatre Suite.

NON-CONFORMANCES

Operating Theatre

a) The recovery room has no beds.
b) The Operating theatre doors all need to be repaired or replaced.
c) The theatre lighting is dull in intensity.
d) The disposal of waste needs to be revised in order to conform to the standards
e) A new supply of theatre clothes needs to be procured. A number of the current ones are riddled with holes
f) Face masks are not being worn in the operating room.
g) Hand washing reminders are required .
h) The bed in the storage room is to be removed and placed elsewhere.

SUMMARY OF AUDIT FINDINGS BY HOSPITAL AND SERVICE AREAS

- Operating Theatre Suite (Management)
- Accident and Emergency Department

Maternity/ Obstetrics Unit

- Intensive Care Unit
- Neonatal Nursery

- Operating Theatre Suite (Infection Control)

SUMMARY RATING FOR THE MANAGEMENT OF OPERATING THEATRE SUITES IN SERHA

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)								
#	**INDICATORS**	**STH-Main**	**STH-Maternity**	**BHC**	**NCH**	**PMH**	**KPH**	**VJH**
1	There is a documented system in place for the efficient and effective use of the Operating Theatre	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
2	There is an effective system to identify, monitor and track the clinical outcome for the Operating Room	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
3	There is a system in place to implement, monitor and evaluate infection prevention and control	PARTIAL	MINIMAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	PARTIAL
4	There is a documented system in place to assess the compliance to personnel policies relating to orientation, role definition, appropriate utilization, training and performance review of all persons working in the Operating Theatre	SUBSTANTIAL	MINIMAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)								
#	**INDICATORS**	**STH-Main**	**STH-Maternity**	**BCH**	**NCH**	**PMH**	**KPH**	**VJH**
5	There is a system in place for the management of the inventory of equipment supplies and for the preventative maintenance of equipment to maintain quality patient care	PARTIAL	PARTIAL	SUBSTANTIAL	MINIMAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL
6	There is an effective system of communication relating to the schedules of operation that flows from the point of contact through the wards, OT and back to the wards and outpatient departments that enhances productivity and quality care	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	MINIMAL	SUBSTANTIAL	SUBSTANTIAL
7	There are risk management procedures to ensure the safety of patients and staff	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
OVERALL SCORE		**SUBSTANTIAL (8)**	**PARTIAL (5)**	**SUBSTANTIAL (10)**	**SUBSTANTIAL (7)**	**SUBSTANTIAL (7)**	**SUBSTANTIAL (10)**	**SUBSTANTIAL (7)**

- All hospitals achieved at least 70% compliance with the standards except NCH. The highest scores were achieved by BHC and KPH.
- NCH needs to improve the management systems in their Operating Theatre Suite.

SUMMARY RATING FOR THE ACCIDENT AND EMERGENCY DEPARTMENTS IN SERHA

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)					
#	**INDICATORS**	**BHC**	**STH**	**PMH**	**KPH**
1	There is a safe and healthy environment	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL
2	Equipment is properly inventorised and maintained	ABSENT	PARTIAL	SUBSTANTIAL	SUBSTANTIAL
3	Orientation is provided for all staff when they join the department	PARTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL
4	There is effective organization and management of the department	SUBSTANTIAL	PARTIAL	PARTIAL	PARTIAL
5	There is a process for the proper reception of patients	SUBSTANTIAL	PARTIAL	PARTIAL	PARTIAL
6	There is an effective triaging system	SUBSTANTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL
7	The department can access emergency diagnostic services	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL
8	There is an efficient supply management system	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
9	Patients and their family/friends are given appropriate information and counselling	SUBSTANTIAL	PARTIAL	PARTIAL	SUBSTANTIAL
10	There is a patient complaints system in place	SUBSTANTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL
11	Patient information is appropriate documentation and fulfills medico-legal requirements	SUBSTANTIAL	SUBSTANTIAL	MINIMAL	SUBSTANTIAL
12	The care and treatment process as a whole is consistent with legislative requirements, standards of practice and the respective code of ethics of each team member	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
13	There is appropriate implementation and integration of clinical practice guidelines and evidence-based care and treatment	SUBSTANTIAL	SUBSTANTIAL	ABSENT	ABSENT
14	There is a process for reviewing the actual results (outcomes) of care and treatment against the expected results (outcomes)	MINIMAL	PARTIAL	ABSENT	PARTIAL
15	There is a process to meet the need for follow-up after discharge	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)					
#	**INDICATORS**	**BHC**	**STH**	**PMH**	**KPH**
16	There are processes for monitoring and improving the quality of care and treatment	PARTIAL	SUBSTANTIAL	ABSENT	SUBSTANTIAL
OVERALL SCORE		**SUBSTANTIAL (7)**	**PARTIAL (6)**	**PARTIAL (6)**	**SUBSTANTIAL (8)**

- All the A&E departments achieved at least 60% compliance with the standards.
- The highest score was achieved by the A&E department at KPH.
- Clinical practice guidelines are absent at both KPH and PMH.
- PMH needs to conduct an audit to of patient records in order to identify the areas not fulfilling medico-legal requirements.

SUMMARY RATING FOR THE MATERNITY/ OBSTETRICS DEPARTMENTS IN SERHA

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)				
#	**INDICATORS**	**VJH**	**STH**	**PMH**
1	There is a safe and healthy environment	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
2	Equipment is properly inventorised and maintained and supplies and medication are inventorised and monitored	PARTIAL	PARTIAL	PARTIAL
3	Orientation is provided for all staff when they join the obstetric department	SUBSTANTIAL	PARTIAL	MINIMAL
4	There is effective organization and management of the department	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
5	There is a process for the reception of patients	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
6	The department can access emergency diagnostic, blood banking, anaesthetic services and operating theatre facility	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
7	There is a system in place for tracking the patientsô flow in the department and the delivery outcomes	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
8	Patients are given appropriate information and counselling prior to discharge or transfer	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
9	There is a system in place to evaluate and process patients' feedback	PARTIAL	PARTIAL	SUBSTANTIAL
10	Patient information is appropriately documented and fulfils medico-legal requirements	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
11	There is a system in place to ensure the labelling and security of the newborns	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
12	The discharge process as a whole is consistent with standards of practice	PARTIAL	SUBSTANTIAL	PARTIAL
13	There are documented evidence-based clinical practice guidelines for care and treatment	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
14	There is a process for reviewing the actual results (outcomes) of care and treatment against the expected results (outcomes)	SUBSTANTIAL	PARTIAL	PARTIAL

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)				
#	**INDICATORS**	**VJH**	**STH**	**PMH**
15	There is a process to meet the need for follow-up after discharge	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
16	There is a system in place to collect and report the statistical data of the department	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
17	There is a system in place to identify all members of staff	SUBSTANTIAL	PARTIAL	PARTIAL
18	There are processes for monitoring and improving the quality of care and treatment	PARTIAL	ABSENT	ABSENT
OVERALL SCORE		**SUBSTANTIAL (8)**	**SUBSTANTIAL (7)**	**PARTIAL (6)**

- VJH achieved 80% compliance of the standards.
- An efficient supply management system needs to be instituted in the maternity/ obstetric departments in all three facilities.
- More attention needs to be paid to the orientation of clinical staff at the PMH.

SUMMARY RATING FOR INTENSIVE CARE UNITS IN SERHA

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)			
#	**INDICATORS**	**BHC**	**KPH**
1	There are adequate resources (human, investigative and equipment) and sound operational policies and procedures documented to support a functional ICU	PARTIAL	SUBSTANTIAL
2	The location, infrastructure and physical layout of the unit promote optimum care for the critically ill patient.	PARTIAL	SUBSTANTIAL
3	There exists adequate tools, procedures, equipment, supplies and services for the monitoring and support of vital organs:	SUBSTANTIAL	PARTIAL
4	There is effective networking used to enhance patient care where the technology is available.	ABSENT	ABSENT
5	There is a policy for administration of the ICU for admission, management and discharge of patients:	PARTIAL	PARTIAL
6	There are sound measures in place for infection control and surveillance:	PARTIAL	PARTIAL
7	There is a policy for the management of visitors.	SUBSTANTIAL	SUBSTANTIAL
OVERALL SCORE		**PARTIAL (6)**	**PARTIAL (6)**

- Both units achieved 60% compliance with the standards.

SUMMARY RATING FOR NEONATAL NURSERIES IN SERHA

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)				
#	**INDICATORS**	**BHC**	**STH**	**VJH**
1	There is a safe and healthy environment	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
2	Equipment is properly inventorised and maintained	MINIMAL	MINIMAL	ABSENT
3	Orientation is provided for all staff when they join the department	PARTIAL	PARTIAL	PARTIAL
4	There is effective organization and management of the nursery	PARTIAL	SUBSTANTIAL	PARTIAL
5	There is a process for the proper reception of patients	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
6	There is a process of patient assessment	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
7	The department can access emergency diagnostic services	PARTIAL	PARTIAL	SUBSTANTIAL
8	There is an efficient supply management system	PARTIAL	SUBSTANTIAL	MINIMAL
9	Patients are given appropriate information and counselling	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
10	There is a patient complaints system in place	SUBSTANTIAL	SUBSTANTIAL	ABSENT
11	Patient information is appropriately documented and fulfills medico-legal requirements	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
12	The care and treatment process as a whole is consistent with legislative requirements, standards of practice and the respective code of ethics of each team member.	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
13	There is appropriate implementation and integration of clinical practice guidelines and evidence-based care and treatment.	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)				
#	**INDICATORS**	**BHC**	**STH**	**VJH**
14	There is a process for reviewing the actual results (outcomes) of care and treatment against the expected results (outcomes)	SUBSTANTIAL	PARTIAL	PARTIAL
15	There is a process to meet the need for follow-up care after discharge	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
16	There are processes for monitoring and improving the quality of care and treatment.	PARTIAL	MINIMAL	MINIMAL
17	There are adequate resources (human, investigative and equipment) and sound operational policies and procedures documented to support a functional nursery	SUBSTANTIAL	PARTIAL	PARTIAL
18	The location, infrastructure and physical layout of the unit promote optimum care for the critically ill patient.	PARTIAL	SUBSTANTIAL	PARTIAL
19	There exists adequate tools, procedures, equipment, supplies and services for the monitoring and support of vital organs:	SUBSTANTIAL	PARTIAL	PARTIAL
20	There are sound measures in place for infection control and surveillance:	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
21	There is a policy for the management of visitors.	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
OVERALL SCORE		**SUBSTANTIAL (8)**	**SUBSTANTIAL (7)**	**PARTIAL (6)**

- The general environment of the VJH nursery needs improvement. BHC nursery achieved the highest compliance with the standards.

SUMMARY RATING FOR INFECTION CONTROL IN OPERATING THEATRES IN SERHA

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)								
#	**Indicators**	**STH-Main**	**STH-Mat**	**BHC**	**NCH**	**PMH**	**KPH**	**VJH**
1	Physical environment is conducive to infection prevention and control	MINMAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	MINIMAL
2	System in place to implement, monitor and evaluate infection prevention and control	ABSENT	SUBSTANTIAL	PARTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	MINIMAL
3	There are adequate equipment and supplies for handwashing	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
4	Handwashing rules for surgical scrub re observed by all staff	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
5	The proper attire is adhered to by all staff	PARTIAL	SUBSTANTIAL	PARTIAL	MINIMAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL
6	The procedures for traffic flow and activity patterns are followed in the transition zone	MINMAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	MINIMAL

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)								
#	**Indicators**	**STH-Main**	**STH-Mat**	**BHC**	**NCH**	**PMH**	**KPH**	**VJH**
7	The procedures for traffic flow and activity patterns are followed in the semi restricted areas	PARTIAL	NOT APPLICABLE	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
8	The procedures for traffic flow and activity patterns are followed in the restricted areas	PARTIAL	SUBSTANTIAL	PARTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
9	Procedures for the cleaning of the rooms before procedures are followed	SUBSTANTIAL	SUBSTANTIAL	PARTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
10	The procedures for the flow of clean and soiled supplies, instruments, linen and equipment are followed	MINMAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL	PARTIAL	PARTIAL	PARTIAL
11	The procedures for the disposal of instruments, linen and waste after surgical procedures are followed	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)								
#	**Indicators**	**STH-Main**	**STH-Mat**	**BHC**	**NCH**	**PMH**	**KPH**	**VJH**
12	The procedures for the cleaning of rooms between and after surgery are followed	PARTIAL	SUBSTANTIAL	PARTIAL	PARTIAL	SUBSTANTIAL	PARTIAL	PARTIAL
13	The procedures for the total cleaning of the surgical rooms are followed	PARTIAL	SUBSTANTIAL	PARTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
14	The procedure for the routine cleaning of the operating theatre as outlined in the departmentôs operational policy manual is followed	PARTIAL	SUBSTANTIAL	PARTIAL	PARTIAL	ABSENT	SUBSTANTIAL	MINIMAL
15	The procedure for cleaning after an infected case is followed	MINMAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
16	The procedure for the decontamination of the cleaning equipment are followed	MINMAL	PARTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)								
#	**Indicators**	**STH-Main**	**STH-Mat**	**BHC**	**NCH**	**PMH**	**KPH**	**VJH**
17	There are adequate procedures for the cleaning and decontamination of instruments/ furniture	PARTIAL	MINIMAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
18	There is a procedure for the storage of sterile or high-level disinfected items	MINMAL	PARTIAL	SUBSTANTIAL	MINIMAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
19	There is an appropriate cleaning procedure for the operating theatre department	MINMAL	MINIMAL	PARTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL
20	The department presents a clean appearance	PARTIAL	PARTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
21	The health care personnel follow the gowning procedures	PARTIAL	SUBSTANTIAL	PARTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
22	The procedures for the use of antiseptics (for skin and/or mucous membranes) are followed	PARTIAL	PARTIAL	SUBSTANTIAL	PARTIAL	SUBSTANTIAL	SUBSTANTIAL	PARTIAL

Rating Scale: NA= Not Applicable, NC= Non Compliant, M= Minimal (1-3), P= Partial (4-6), S= Substantial (7-10)								
#	**Indicators**	**STH-Main**	**STH-Mat**	**BHC**	**NCH**	**PMH**	**KPH**	**VJH**
23	The procedures for the decontamination of instruments and other articles are followed	MINIMAL	ABSENT	SUBSTANTIAL	ABSENT	SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
24	There is a system is in place to monitor the health status of staff assigned to the department	ABSENT	ABSENT	MINIMAL	MINIMAL	PARTIAL	SUBSTANTIAL	PARTIAL
OVERALL SCORE		**PARTIAL (5)**	**SUBSTANTIAL (8)**	**SUBSTANTIAL (8)**	**SUBSTANTIAL (7)**	**SUBSTANTIAL (9)**	**SUBSTANTIAL (9)**	**PARTIAL (6)**

- The lowest compliance was at the Spanish Town Hospital Operating theatre.
- All operating theatre suites achieved at least 60% compliance with the standards for infection control in the theatres.

APPENDICES

- Photos: Conformances and Non-Conformances
- Audit Tools

Red and Black Bags in Garbage Containers

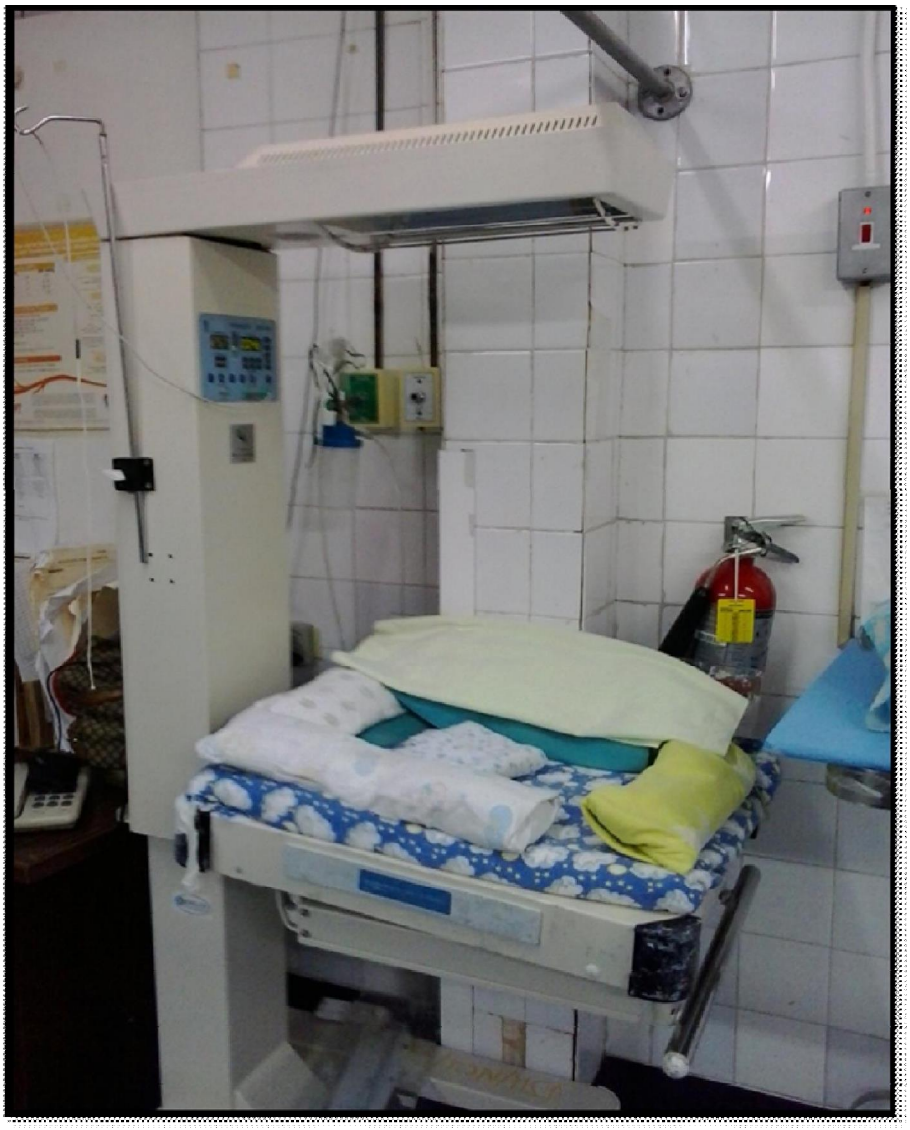
CONFORMANCE

Scrub Room with Foot Operated Hand Soap Receptacle

CONFORMANCE

Patient Complaint Area (STH)

CONFORMANCE



Resuscitaire

NON-CONFORMANCE

Operating Theatre Door

NON-CONFORMANCE

Instruments soaking in Plastic Container

NON-CONFORMANCE

Red and Black Bags stored in Passageway

NON-CONFORMANCE

Roof of Sluice Room

NON-CONFORMANCE

Make-shift Sharps Container

NON-CONFORMANCE

Sluice Room

NON-CONFORMANCE

AUDIT INSTRUMENT FOR THE INFECTION CONTROL PROGRAMME IN OPERATING THEATRE DEPARTMENT

☐**External Audit** ☐ **Internal Audit** ☐**Surveillance Audit**

Health Facility:_____**Audit Date:** _____

Audit Team Members/Monitoring Officer:_____

Key Rating: N= Not Applicable or Non Compliant, Insert **NC** or **NA** as appropriate, **M**= Minimal (1-3), **P**= Partial (4-6), **S**= Substantial (7-10), Insert **"X"** as appropriate (numerical rating)					
Indicator	**RATING**				**COMMENTS**
	N	**M**	**P**	**S**	
STANDARD 1					
There is a documented system in place for the efficient and effective use of the Operating Theatre					
• The Operating Theatre is available for use 24hrs/day, 7 days/week					
• Planned operating sessions are scheduled between 8am and 4pm, Mondays to Fridays and begin promptly to ensure best use of available facilities					
• One theatre if possible should be dedicated for emergencies					
• In the event of emergencies, planned lists (between 8am and 4pm) may be interrupted to accommodate these changes					
• The first patient on the list is collected from the wards by the orderly 1/2 hour prior to the start of the list. The name of the first patient for each list is left on the stretcher for the Orderlies by the Senior Nurse (night) before she goes off duty.					
• Each Operating Room is cleaned IMMEDIATELY after each case; the cleaning process takes no longer than 15 minutes.					
• Patients arrive in OT adequately prepared:					
- had a bath on the morning of surgery					

- wearing clean OT gown +/- cap (if locks, long hair)					
- hair washed at least day prior to surgery					
- jewelry, dentures removed					
⬮ The patient is not brought into OT until OT is ready for use i.e. all the required staff and documentation relevant to the case are available					
⬮ The patient is at all times received by a nurse who is assigned by Sister in charge					
⬮ The receiving Nurse:					
- checks the patient's identification					
- checks that the patient is adequately prepared					
- checks that medical records, X-rays accompany the patient and that the blood is available					
- ensures that the patient has received the relevant pre-medication					
⬮ When necessary, the surgeons arrange with the blood bank to have blood prepared and delivered to the OT in advance prior to elective surgery and expeditiously for emergencies					
⬮ The handover of medical/nursing information must be made between the appropriate OT and ward nursing staff. The OT Orderly should not be expected to communicate medical information to the ward staff					
⬮ Day surgical procedures are carried out in the regular operating theatre list					
STANDARD 2					
There is an effective system to identify, monitor and track the clinical outcome for the Operating Room					
⬮ The supervisors of each discipline (Nursing, Surgery, Anaesthetics) ensure that the optimum-staffing cadre is in place per operating theatre, using the patient classification system, so as not to jeopardize quality of care.					

• An Anaesthetist assesses the patient's fitness for surgery.					

⬮ Patients with medical illnesses are referred to the Consultant Anaesthetist +/or Consultant Physician as early as possible for assessment. The medical condition is stabilized and deemed optimal before being posted on the operating list.					
⬮ Medically unfit patients are cancelled or rescheduled by the Consultant Anaesthetist or Consultant Surgeon.					
STANDARD 3					
There is a system in place to implement, monitor and evaluate infection prevention and control.					
⬮ Staff coverage after 4 PM on week nights, and on the weekends are planned to function around emergency surgery to allow for OT to acceptable standard of cleanliness and readiness.					
⬮ The OT is thoroughly cleaned and disinfected at a specified time leaving one theatre fully functional and available for emergency surgeries only.					
⬮ Specific procedures are followed when dealing with infectious/infected cases:					
- such cases are done at the end of the list					
- on necessary equipment are cleared from the operating room prior to start					
- disposable clothing, overshoes, drapes, equipment [if available] are used					
- A nurse outside the OR is available to retrieve anything needed outside of that theatre					
- staff involved in the case remain until complete					
- specific cleaning and disinfecting procedures are carried out post procedure					
⬮ Specific hand washing and surgical scrubbing techniques are utilized and adhered to (using particular agents and methods).					
⬮ Universal precautions are observed and adhered to by all staff members.					
⬮ OT Sister ensures that infection control policies and procedures are strictly observed by staff.					

• Bacteriological swabs are taken from specific areas in the OT monthly or at most quarterly and sent to the laboratory.					
• The Clean Zone is clearly delineated and access is restricted and subject to specific procedures:					
- Patients are transferred from ward stretcher to clean OT stretcher					
- Equipment and supplies are properly cleaned prior to entering the Clean Zone					
- Non-Operating staff and visitors must don theatre clothing in order to enter					
- Outpatient enter and leave OT via the changing rooms					
- Only clean OT clothes (caps, scrubs, gown) and shoes are worn beyond the red line; if worn outside new clean garb is needed for re-entry					
• There is a procedure in place to maintain sterility and integrity of supplies between CSSD and OT.					
1. Un-sterile supplies are sent for sterilization by 6 PM and return by 7 AM (logbook maintained)					
2. Instruments sets are adequately washed and wrapped and appropriately accounted for (content chart/check list)					
3. A full range procedure sets covering all possible surgical procedures are available. Urgent sterilization is undertaken by the OT staff using the Autoclave.					
4. Trolley transporting sterile supplies should be covered impermeable material.					
5. The trolley stays in CSSD overnight to be repacked with sterile items, is then collected and delivered to OT every morning by the OT Orderlies by a time specified by Sister.					
STANDARD 4					
There is a documented system in place to assess the compliance to personnel policies relating to orientation, role definition, appropriate utilization, training and performance review of all persons working in the Operating Theatre.					

• Every patient has a valid consent form signed indicating their agreement to surgery and anaesthesia.					

• New consent is required for each different surgical procedure on the patient.					
• Patients 16yrs and older sign their own consent; if not competent to do so (insane, mentally retarded, unconscious) it may be signed by parent, guardian, spouse, next of kin.					
• Senior Medical Officer may give consent if patient unable to sign for an emergency operation.					
• Restricted consent (i.e. consent for treatment in general but refusal of specific aspects e.g. surgery but no blood for Jehovah's Witnesses) must be clearly documented and risks explained to patient.					
• All day surgery patients should be booked, elective cases.					
• They should have been screened in surgical clinics by surgical team and anaesthetic team for suitability and issued the pertinent instructions at the time of the outpatient consultation					
• Day surgery cases start as early as possible to allow adequate recovery time and avoid use of a hospital bed.					
• Patients should be encouraged to be accompanied by a relative or friend who will wait with them, assist them throughout the day and ensure their safe transport home.					
• All patients having General Anaesthesia must be accompanied by a responsible adult.					
• Private patients are admitted through the regular hospital admission process and included on the regular OT list. Patients' slips should clearly state "private".					
• The ratio of public to private patients should be no greater than 3:1 on any one list.					
STANDARD 5					
There is a system in place for the management of the inventory of equipment supplies and for the preventative maintenance of equipment to maintain quality patient care.					
• Operating Lists are planned with regard to the available sessions, facilities, equipment and staff.					

• Operating Lists are agreed upon by the Departmental Sister, Surgical Firm Consultant and Anaesthetic Consultant at least 1 day in advance.					

• Operating lists are typed and distributed by 12pm on the day prior to surgery					
STANDARD 6					
There is an effective system of communication relating to the schedules of operation that flows from the point of contact through the wards, OT and back to the wards and outpatient departments that enhances productivity and quality care.					
• OT Department Manager/Departmental Sister in place					
• There is close communication and liaison between OT Department Manager/Departmental Sister and key staff eg. Medical Records etc.					
STANDARD 7					
There are risk management procedures to ensure the safety of patients and staff.					
• Additional staff may be summoned by Sister (after consultation with medical staff) to assist in the event that several emergencies arise outside scheduled working hours.					
• When emergency surgery is required, the Surgical Resident 'on call' arranges with the 'on call' Anaesthetist to do the case; and arranges for use of the OT with the Senior Nurse on Duty who will mobilize the OT Nursing staff.					

AUDIT INSTRUMENT FOR THE MATERNITY/OBSTETRICS UNIT

☐**External Audit** ☐ **Internal Audit** ☐**Surveillance Audit**

Health Facility:_____**Audit Date:** _____

Audit Team Members/Monitoring Officer:_____

STANDARD	**RATING**					
Indicator **1. THE POLICIES ARE FOLLOWED FOR THE REGISTRATION AND BOOKING OF PATIENTS IN THE ANTENATAL CLINIC.**	**N**	**A**	**M**	**P**	**S**	**REMARKS**
⧫ All patients present their maternal record book for inspection and updating in the Antenatal Clinic						
⧫ The antenatal register in the Antenatal Clinic is kept up-dated, listing all attending mothers and relevant information.						
⧫ The patientôs medical record is: - Up-dated at each visit - Filed in the Registry for the next visit						
⧫ All patients have at least one blood donor slip pinned in their maternal record book.						

• All pregnant women are sent for booking at the hospital where they wimll deliver after all blood investigations are completed and no later than 34 weeks of pregnancy.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator **2. THERE ARE POLICIES TO ENSURE QUALITY MANAGEMENT OF PATIENTS IN THE ANTENATAL CLINIC**	**N**	**A**	**M**	**P**	**S**	**REMARKS**
• All pregnant patients are seen at least once by a Medical Doctor during their pregnancy.						
• **All high risk pregnant patients are seen initially by a specialist at each visit to the Antenatal Clinic under his/her supervision for subsequent visit.*						
• All low risk pregnant patients are seen on a regular basis by the appropriate health practitioner eg. Midwife						
• All low risk pregnant patients are advised to attend health centre clinics at specific stages of the pregnancy.						
• All pregnant women have the following minimum blood investigation completed early in the pregnancy. - Blood group - Rhesus status - Haemoglobin level - HIV - VDRL - Sickle test						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator **3. THERE ARE ADEQUATE HUMAN RESOURCES TO SUPPORT A FUNCTIONAL OBSTETRICS DEPARTMENT**	**N**	**A**	**M**	**P**	**S**	**REMARKS**
• There are adequate numbers of: - **Consultants* - Senior Residents - Medical Officers - **Anaesthetists* - Nurse Anaesthetists - **Peadiatricians* - Interns - Ward Sisters - Registered Nurses / Midwives - Midwives - Enrolled Assistant Nurses - Ward Assistants - Health Records Personnel - Maternity Ward Clerks - **Social Worker*						
• There is an appropriately trained Medical Officer on call on the compound at all times.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

• There is a Specialist on call and accessible at all time						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator	**N**	**A**	**M**	**P**	**S**	**REMARKS**
4. THERE IS ACCESS TO ADEQUATE LABORATORY SERVICE:-						
- Full blood count, Sickle Cell - Coagulation Profile - Blood Group & Rh - Serum electrolyte - Urea and creatinine, bilirubin - Blood glucose - Urine pregnancy tests - Urinalysis - HIV						
• There is provision for blood banking on compound or within easy access.						
5. THERE IS ACCESS TO ESSENTIAL COMPLEMENTARY SERVICES:-						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

- **Internal Medicine* - **Psychiatric Specialist* - **Social Worker* - Anaesthetics Service - Imaging (**Ultrasound*, Xrays) - **Neonatal Care Support Services** . Resuscitation . Warm Incubation . Phototherapy . Warm incubation						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator **6. THERE ARE ADEQUATE EQUIPMENT, SUPPLIES AND DRUGS TO SUPPORT A FUNCTION**	N	A	M	P	S	REMARKS
- Sphygnomonometer (manual and electronic) - Scales (Adult and Neonatal) - Blood glucose testing machine - Fetoscope ï Pinard - Foetal heart monitor (hand held Doppler) - Thermometers - Stethoscopes - Resuscitation equipment (Adult and Neonate) - Infant Warmer - Resuscitaire - Suction Machine - **Ultrasound Machine* - *Pulse Oximeter*						
⧫ The essential non-clinical equipment are available / or within easy access:- - Wheelchairs (minimum 3) - Stretchers						
⧫ There is a list of required equipment.						

• The following essential drugs are available:- - Pitocin (Oxytocin) Injection (10 units ampoules) - Syntometrine Injection (10 units ampoules) - Methergin Injection (2mg ampoules) - Konakion Injection - Lignocaine Injection (2%, 10ml) - Hydrallazine Im/iv (20mg per ml) - Magnesium Sulphate Injection - Diazepam Injection (10mg/ampoules) - Phenergan Injection (25 mg/ampoules) - Analgesics Im/iv						

- Pethidine (50mg ampoules) - NO-SPA 40mg ampoule - Baralgin 2mg ampoule - **Antibiotics IM/IV** . Amoxicillin . Gentamicin . Metronidazole - **Eye Infection Prophylaxis** . Tetracycline Eye Ointment . Erythromycin Eye Drops						
• The following essential supplies are available: - Intravenous Fluids 5% D/W, N/S, Hartman Solution - Gelofusin - Antiseptics - Suture material - Supplies of needles, syringes, iv intracatheter, and blood tubes - Sterilized gauze, cotton, gloves, and gowns - Sterilized delivery packs and sets - Clean linen sets - Maternity pads - Liquid Soap - Supplies of Oxygen - Supplies of Oxygen Gauges - Masks - Goggles						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATIN					
Indicator **7. THERE IS ACCESS TO AND KNOWLEDGE OF RELEVANT POLICY DOCUMENTS.**	N	A	M	P	S	REMARKS
• Staff have knowledge of the Inter-hospital Transfer Policy and are able to access a copy of the guidelines for: - Referring and accepting institutions - Ambulance services - CASEVAC (helicopter)						
• There is an Obstetrics Department / Maternity Ward Policies and Procedures manual which is easily accessible to all members of staff working in the department / ward.						

N = **Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate**

STANDARD	RATING					
Indicator **8. THERE ARE SYSTEMS IN PLACE TO ENSURE THAT ETHICAL AND LEGAL RIGHTS ARE NOT COMPROMISED.**	N	A	M	P	S	REMARKS
• Confidentiality of patient information is maintained through:- - Limited access to patientsô medical records - Proper storage of patientsô medical records						

• There is access and use of consent forms (Release of Client Information MOH-Doc-5000-31.5) for the release of patientsô medical records.						

•	There is access and use of consent forms for photography and the release of photographs for publicity purposes.						
•	The patientsô privacy during delivery is ensured through:- - Enclosure of delivery area - Limited access to delivery area (doctors / nurses / midwives)						
•	Each patientôs name, address and telephone number of next of kin are recorded in the maternal record book and in the patientôs medical record on admission.						
•	Each patient signs consent / Authorization for: - All procedures (including blood transfusions) - Disposal of a foetus / newborn / stillborn (Authorization for Burial / Disposal of Deceased Newborn / Stillborn Form) - Accompanied medical transportation						
•	All patients under 16 years have a parent / guardian / relative sign the consent / Authorization for Treatment Form and have form witnessed by a doctor / registered midwife / nurse.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	**RATING**					
Indicator	N	A	M	P	S	REMARKS
• All post mortem request forms are completed by a doctor.						
• All Certificate of Stillbirth Forms are completed by a certified midwife.						

• Each patient who dies in the department / ward has a Death Form completed by a Doctor.						

• An Investigation Form (Maternal Mortality Surveillance Form) is completed for each maternal death and report made within 24 hours. (Class 1 notifiable disease)						
• All mothers have their babies registered prior to discharge.						

STANDARD	**RATING**					
Indicator **9. THERE ARE POLICIES AND PROCEDURES TO SUPPORT THE EFFECTIVE MONITORING OF THE USE OF DANGEROUS DRUGS ON THE WARD.**	N	A	M	P	S	REMARKS
• There is a secure cupboard on the ward for storage.						
• The drugs are checked off at the beginning and ending of each shift by the assigned nurse.						
• There is a system in place for monitoring ward stock and collection of dangerous drugs.						
• Drug Orders are signed by the Registered Medical Practitioner.						
• The drug orders are checked by the assigned nurse and the witness.						
• The preparation of drugs for administration is done by the assigned nurse in the presence of the witness and documented in the nursing notes.						
• The drug is administered to the patient by the assigned nurse in the presence of the witness and documented in the nursing notes.						

• The details of administration are entered in the Dangerous Drug Register and includes: - Name of patient - Patient medical record number - Amount of drug administered (Date, Time) - Drug balance remaining - Signature of person administering and witnessing						

⬮ All accidents / loss of dangerous drugs must be reported to the Chief Dangerous Drug Inspector (MOH), through the Chief Pharmacist and through the Director of Nursing in the facility.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	**RATING**					
Indicator **10. THERE ARE STANDARD OPERATING PROCEDURES FOR IN-PATIENT MANAGEMENT.**	N	A	M	P	S	REMARKS
⬮ All patients are admitted to hospital by a midwife / nurse.						
⬮ There is an area on the ward clearly identified and marked for antenatal admissions.						
⬮ All un-booked patients who arrive at the hospital for admission are assessed to determine what action should be taken.						
⬮ **All high risk patients are admitted to the High Risk Room (Types A, B and Specialist hospitals)*						
⬮ All admitted patients have the following completed: - Comprehensive biodata / social history / PMH / Surgery history - Clinical History - Examination - Plan of action for medical and nursing interventions						
⬮ All doctors referring patients (within and outside of the hospital) do so in writing using approved referral forms.						

• All patients are prepared for labour as follows: - Examination - Perineal and abdominal shave for Caesarean section patients - Clothed in delivery gown as appropriate - Blood Investigations completed (VDRL, HIV, Hb Group, Rhesus, Sickle Test, Urine Analysis)						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	**RATING**					
Indicator **11. THERE ARE STANDARD OPERATING PROCEDURES FOR ROUTINE CLINICAL CARE FOR ALL PATIENTS ON THE WARD.**	N	A	M	P	S	REMARKS
• All patients have their vital signs (temperature, pulse, respiration and blood pressure) monitored at least twice daily.						
• All patients have their urine tested at least once daily for: - Protein - Glucose - Ketones						
• All patients on the ward have their foetal heart tone tested once each shift.						
• All patients are weighed on admission.						

• All patients who are induced have the following: - A special monitoring chart. - An assigned person responsible for monitoring.						
• **All patients who have non-conventional methods of induced labour (Misoprostol) are managed by an Obstetrician.*						

⬮ **Each patient in the High Risk Room (Type A, B and Specialist hospitals) is monitored by the midwife at least every 30 – 60 minutes but more frequent if her course is not proceeding normally.*						
⬮ At the start of active labour a midwife / nurse initiates a partograph.						
⬮ The progress of the labour is charted on the partograph.						
⬮ All results and drugs given are recorded on the patientsô labour record chart / partograph.						
⬮ The following charts and records are completed in full and up-dated regularly: - Labour record charts / partograph - Infant charts - Records of vital signs						
12. **THE FACILITIES FOR LABOUR AND DELIVERY ARE ADEQUATE.**						
⬮ The physical layout of the labour and delivery rooms allows for patientsô privacy.						
⬮ The following are available on each labour ward: - Hand washing basin - Toilet						
⬮ There is adequate space for the equipment to monitor the foetal heart.						
⬮ There is an adequate number of beds in the delivery room (4-5 beds/500 deliveries per year).						
⬮ There is a separate room which is used for isolation.						
⬮ The delivery room is equipped with the following: - A delivery table/bed which is adjustable and has stirrups. - An instrument trolley with the following: ➢ IV lines, branulas ➢ Needles						

➢ Syringes of various sizes ➢ Intravenous fluids ➢ Alcohol ➢ 2 pairs scissors ➢ 4 artery forceps ➢ 2 kidney dishes (Medium and Large) ➢ Sterile and non sterile gloves ➢ Urinary Catheters ➢ New suction catheters ➢ A syringe with Oxytocin						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	**RATING**					
Indicator	N	A	M	P	S	REMARKS

➢ Needle holders ➢ Tissue forceps ➢ Sutures ➢ Blood tubes ➢ Investigation forms ➢ Intra-catheters for intravenous access ➢ Lubricant jelly ➢ Hibitane obstetric crème ➢ Cord clamp/umbilical tapes ➢ Cotton balls ➢ Gauze ➢ Sanitary pads ➢ Cleaning agent - Adequate lighting - Instrument and equipment sets - Suction machine - Emergency box with medication and sundries for						

resuscitation - Warm dry linen for receiving and warming an infant - Oxygen and suction outlets for treatment of mother and infant - An area prepared for the resuscitation of the newborn (Resuscitaire) - An emergency call system - A wall clock - A scale for weighing the infant - A stretcher - Identification tags/ bracelets - Foetal heart Doppler						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator	N	A	M	P	S	REMARKS
• The following medications are available in the delivery room: - Pitocin Injection - Syntocinon Injection - Konakion Injection - Silver Nitrate eye drops/ Tetracycline eye ointment/ Erythromycin eye drops - Magnesium Sulphate Injection - Hydrallazine Injection - Pethidine Injection (50 mg amopoules) - Chlopromazine (Largactil) 25 mg - Drotaverinum (Nopsa) Injection 40 mg - 2% Lignocaine Injection, Ten international units - Syntometrine - Methergin - Sodium Bicarbonate - Misoprostol (for P.P.H)						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator 13. **IN THE LABOUR AND DELIVERY ROOMS THERE ARE STANDARD OPERATING PROCEDURES TO ENSURE QUALITY CLINICAL CARE.**	N	A	M	P	S	REMARKS
• In the labour and delivery rooms, the doctor on duty is informed of all cases of premature labour and delivery of premature infants.						
• A doctor from the Paediatrics Department is in attendance at all Caesarean Sections for patients with high risk conditions						
• Each baby is clearly identified/ tagged and leaves the hospital wearing the tag						
• The babies of all Rhesus negative mothers have cord blood collected and sent for testing						
• All critically ill and premature infants weighing less than 2000 grams at birth are transferred to a Special Care Nursery						
• All patients after normal delivery are transported from the Delivery Room in a wheelchair/stretcher by a midwife/nurse						
• All patients after a Caesarean Section are transported from theatre on a stretcher						

• The sections 1-6 on the Obstetrics Record Summary Form are completed by the nurse who did the delivery, before the patient is transferred to the ward.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator 14. **THERE ARE STANDARD OPERATING PROCEDURES FOR POST NATAL CARE**	N	A	M	P	S	REMARKS
⬮ After delivery, a warm drink is provided to all patients (except for patients who had Caesarean Section or who are sedated).						
⬮ All healthy normal newborn babies are given to their mothers on the ward.						
⬮ There are no ñbabyò bottles in use on the maternity ward.						
⬮ There is an immunization programme at the hospital -Babies are given BCG immunization prior to discharge.						
⬮ At birth record is kept on the baby, monitoring the following: - Skin Colour - Temperature - Heart Rate - Number and Type of stool - Any vomiting - Urination - Movement - Response to feeling and handling						
⬮ There is referral access to a Paediatrician/ Paediatric Resident to conduct a physical examination and evaluation on infants when applicable.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator 15. **THERE ARE POLICIES AND PROCEDURESTO ENSURE RESUSCITATION EFFORTS YIELD POSITIVE OUTCOMES.**	N	A	M	P	S	REMARKS
• Resuscitation drills for adults and newborns and conducted every six (6) months for the nursing and medical staff.						
• Staff attendance at the resuscitation of delivery is compulsory.						
• There is an attendance record kept for each resuscitation drill.						
The attendance records demonstrate that greater than 80% of staff attended a drill session within the last year.						

• The following resuscitation equipment is present on the resuscitation trolleys: <u>Suction Equipment</u> - Bulb syringe - Mechanical suction - Suction catheters 5F or 6F, 8F or 10F - Meconium aspirator <u>Bag and Mask Equipment</u> - Neonatal resuscitation equipment - Face masks (adult and neonate) - Oral airways (adult and neonate) - Humidified oxygen with regulators - Flow meter tubing <u>Intubation Equipment</u> - Laryngoscope with straight blades 0,1 (Adult and Neonate) - Endotracheal tubes 2.5, 3.0,3.5,4.0 (Adult and Neonate) - Stylet - Scissors - Gloves (Medium and Large)						

- Batteries for laryngoscopes						
• The following medication for resuscitation are present: - Epinephrine Injection - Naloxone Injection - Volume Expanders 5% Albumin, Normal Saline, Ringerôs Lactate - Sodium Bicarbonate Solution 4.2%- adult 8.4 - Dextrose Water (10%) - Sterile Water						
• The following sundries for resuscitation are present: - Radiant warmer- minimum of two (2) - Stethoscope - Adhesive tape - Syringes 1,3,5,10,20 ml - Needles 25,21 and 18G - Alcohol swabs - **Umbilical Catherization Tray* - Umbilical clamp - **Umbilical Catheters 3.5F, 5F* - Feeding tubes 5F 6F 8F 10F - IV Lines - Examination lamp - Paediatric Buretol						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator 16. **THERE ARE SAFETY REGULATIONS AND MECHANISMS TO PROTECT MOTHERS AND THEIR INFANTS.**	N	A	M	P	S	REMARKS
• There is 24 hour direct contact for staff and patient with the labour and delivery area.						
• There is an emergency communication mechanism on every ward to facilitate patients in distress.						
• All patients are given an identification bracelet up on admission.						
• Each baby has the ID bracelet, checked prior to transfer and at the time of receiving on the postnatal ward and nursery. This must be documented in the nursing notes.						
• Each baby has his/her name on the identification bracelet checked against the registration paper of the mother before leaving the hospital. This is done by the security guard.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator	N	A	M	P	S	REMARKS
17. **THERE ARE ADMINITRATIVE, MEDICAL AND SAFETY SYSTEMS IN PLACE FOR RISK MANAGEMENT.**						
Administrative Procedures • Clinical notes are made on every patient formally seen/ admitted to hospital/ ward on the prescribed form. These notes should be:- - Legible - Sequential - Documented with date and time and signed						
• All corrections in the patientsô medical records follow the procedures outlined in the Obstetrics Department/Maternity Ward Policies and Procedures Manual.						
Clinical Management • There are labour ward protocols which are: - Accessible - Up-dated regularly						
• There are clear guidelines for: - The management of common Obstetrical emergencies - **The interpretation of Cardiotocograph (CTG) tracings where applicable.*						
• All patients are given advice on symptoms of the common complications of pregnancy.						
Equipment • Equipment is maintained to meet safety requirements						
• There is a system in place to report: - defective equipment - failure to maintain equipment						

STANDARD	RATING					
Indicator	N	A	M	P	S	REMARKS
Meeting • There is Perinatal Mortality meeting monthly or more than six (6) meetings annually, involving all categories of technical staff.						
• There are clinical meetings to analyze causes of Maternal Morbidity and Mortality and plan preventive strategies.						
Post-Mortem • A post-mortem is conducted on all maternal deaths.						
• There is a copy of the Death Certification and Mortuary Operations Policies and Procedures manual in the department/ward.						
• There is a Ward Mortuary book present with the following information: - name/mother's name - age - gender - ward of origin - date of death - date of removal						
Fire Drills and Complaints • There is an annual fire training conducted by the Fire Department - relevant certification to be placed on wall						
• There are in-house fire drills annually.						

• There is a system in place for: - Logging and handling complaints - Handling disruptive patients and/or relatives						
Displaced Babies						

• Relevant health workers have been sensitized to the procedure for investigating an abandoned or missing newborn.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	RATING					
Indicator	N	A	M	P	S	REMARKS
18. **THERE ARE STANDARD OPERATING PROCEDURES FOR DISCHARGING PATIENTS FROM THE WARD.**						
• All patients being discharged have their Maternal Record books updated by a doctor and/or midwife/nurse.						
• All patients are given an education talk prior to being discharged. This activity must be documented.						
• The health education talk for postnatal clients should include information on: - Nutrition - Breast feeding - Common problems in the neonates - The Care of the perineum - Family planning - Immunization - Registration of births - Instructions for follow-up visits (when and where) - Instructions regarding common emergencies						

• All patientsô health records must include the relevant nursing discharge notes. The following must also be documented:- - Date and time of departure - Whom the patient departed with and mode of departure.						

⬮ Patientsô medical records must have complete discharge summaries signed by a doctor.						
⬮ All patients are issued a discharge slip before leaving the ward.						
⬮ All discharged patients have their names recorded by the ward clerk on the census sheet and in the admission book.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

STANDARD	**RATING**					
Indicator 19. **THERE ARE MEASURES IN PLACE FOR INFECTION PREVENTION AND CONTROL.**	N	A	M	P	S	REMARKS
⬮ There is a copy of the Health Facilities Infection Control Policies and Procedures Manual (MOH, 2000) in the department/ward.						
⬮ There are wash basins strategically located in the department/ward. - 2 wash basins per service area - 1 wash basin per 10 beds						
⬮ Proper hand washing practices are observed.						
⬮ All attendants in the delivery room wear the following: - sterile gown - sterile gloves						
⬮ There is a cleaning schedule for the department/ward.						

• All sharps are disposed of in puncture-resistant receptacles immediately after use.						
• All sharp receptacles are removed from the department/ward when 2/3 full.						
• All infectious waste is placed in receptacles with the						

appropriate bags.						
• All receptacles with infectious waste are removed from the department/ward when 2/3 full.						
• The resuscitation equipment is cleaned as per standard and replaced immediately after use.						
• All equipment and instruments are cleaned in accordance with the standards in the Health Facilities Infection Control Polices and Procedures Manual (MOH, 2000).						

STANDARD	RATING					
Indicator 20. **THE DEPARTMENT/WARD HAS AN ACTIVE HOSPITAL SURVEILLANCE PROGRAMME FOR COLLECTING, ANALYZING, INTERPRETING AND DISTRIBUTING RELEVANT INFORMATION.**	N	A	M	P	S	REMARKS
• There is a system in place to collect the following data: - Number of births and deaths - Perinatal morbidity/mortality - Number of stillbirths - Maternal morbidity/mortality - Infection rates - Statistics relating to rout of delivery and induction of labour						
• There is a staff communication mechanism for sharing this information monthly.						
• There is a mechanism for reporting this information to the Ministry of Health.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert X as appropriate

AUDIT INSTRUMENT FOR THE INTENSIVE CARE UNIT

☐**External Audit** ☐ **Internal Audit** ☐**Surveillance Audit**

Health Facility:_____**Audit Date:** _____

Audit Team Members/Monitoring Officer:_____

STANDARD **Indicator**	**RATING**					
	N	A	M	P	S	REMARKS

1. THERE ARE ADEQUATE RESOURCES (HUMAN, INVESTIGATIVE AND EQUIPMENT) AND SOUND OPERATIONAL POLICIES AND PROCEDURES DOCUMENTED TO SUPPORT A FUNCTIONAL ICU • There are adequate numbers of - Consultant Anaesthetists - Medical Officers - Trained ICU nurses. • There is access to specialists in all medical disciplines. • There is at least one trained ICU nurse per 2 beds. • There is an appropriately trained ICU Resident on call and on the compound at all times. • There is a Consultant Anaesthetist on call and accessible at all times.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert "X" as appropriate

STANDARD Indicator	RATING					
	N	A	M	P	S	REMARKS
• There is access to a laboratory offering a full range of investigations: - Microbiology, - Pathology, - Chemical Pathology, - Haematology. • The following equipment are available/or within easy access: - Blood gas machine - Portable X-ray machines - Portable ultrasound - Portable echocardiogram • There is access to CT scan and MRI services. • There exists an Inter-hospital Transfer Policy outlining the transfer policy for: - all referring institutions - ambulance services - emergency medical services (EMS) • There is a 1:1 nurse to patient ratio policy which is adhered to and adjusted according to patient dependency scores and exigencies of service.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert "X" as appropriate

STANDARD Indicator	RATING					
	N	A	M	P	S	REMARKS
• There are protocols for common ICU procedures: - intubations - lines - suctioning • There are daily ward rounds conducted by a Consultant Anaesthetist along with resident(s), sister/nurse in charge to review patient progress and management. • There are daily reviews by the referring medical staff. • There are patient referrals whenever necessary to: - Physiotherapist - Nutritionist - Microbiologists • There are teaching rounds conducted by a Consultant Anaesthetist at least once a week which include a review and discussion of topics of interest.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert "X" as appropriate

STANDARD Indicator	RATING					
2. THE LOCATION, INFRASTRUCTURE AND PHYSICAL LAYOUT OF THE UNIT PROMOTE OPTIMUM CARE FOR THE CRITICALLY ILL PATIENT.	N	A	M	P	S	REMARKS
⬮ The ICU is in close proximity to: - Operating Theatres - Accident and Emergency Department - Fridge for blood storage ⬮ The ICU is air conditioned. ⬮ The ICU is connected to at least one functioning standby generator. ⬮ In each cubicle there are outlets for: - piped medical gases (100% oxygen, compressed medical air and vacuum) ⬮ In each cubicle there are at least 16 electrical outlet sockets (120V and 240V) (3:1 ratio) ⬮ There are battery power sources for - lighting - monitors - other equipment. ⬮ The cubicles in the unit are partitioned (glass or plastic partitioning) from each other allowing for visibility between the cubicles. ⬮ The cubicles in the unit are all visible from the nursing station. ⬮ There is an ICU grade bed in each cubicle.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert "X" as appropriate

STANDARD Indicator	RATING					
	N	A	M	P	S	REMARKS
• There is adequate storage for disposables/medical sundries in the unit and where necessary at each cubicle. • There is adequate storage and space for - ventilators - monitors - other equipment • There is a room designated for counselling and discussions with relatives. • There is a room for staff and to host management meetings.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert "X" as appropriate

STANDARD Indicator	RATING					
3. THERE EXISTS ADEQUATE TOOLS,	N	A	M	P	S	REMARKS

PROCEDURES, EQUIPMENT, SUPPLIES AND SERVICES FOR THE MONITORING AND SUPPORT OF VITAL ORGANS: • There are comprehensive ICU patient charts reflecting systems monitored and interventions made for each patient. • There are means of assessing cardiac output for each patient: - PAC/ trans-thoracic impedance - Echocardiogram (ECG) • There are ward rounds with daily charting and notification of the date, time and name of person conducting the rounds. • There is continuous non-invasive blood pressure, ECG and pulse oximetry monitoring in each cubicle. • There is 24 hours immediate blood gas analysis available. • There is early blood chemistry analysis available. • There is access to dialysis: - peritoneal - haemodialysis - and/or haemofiltration, haemodiafiltration • The following are available in the unit: - Central venous pressure monitoring - Invasive blood pressure monitors - Intracranial pressure monitors. - Blood glucose monitors						

STANDARD Indicator	RATING					
	N	A	M	P	S	REMARKS

• There is a functional defibrillator in the unit. • There are ventilators capable of ventilating patients with a wide range of respiratory disorders of restriction or obstruction and a range of various modalities of ventilation and weaning. The ventilators are also capable of delivering both PEEP and CPAP. • There are artificial feeds in the unit: - enteral and - parenteral feeds • There is an easily mobilized and properly maintained emergency (crash) trolley. • There are adequate pharmacological resources (on a 24 hour basis) to support the following systems: - cardiovascular, - respiratory, - renal, - gastrointestinal, - nervous and immune • There exists all the necessary disposables needed to support the critically ill patient: - endotrachial tubes - nasogastric tubes - catheters - sterile specimen containers • There is access to physiotherapy services.						

STANDARD Indicator	RATING					
4. THERE IS EFFECTIVE NETWORKING USED TO ENHANCE PATIENT CARE WHERE THE TECHNOLOGY IS AVAILABLE.	N	A	M	P	S	REMARKS
ǒ There is use of Local Area Networks that permit **TIMELY** access to information either through a central ICU CPU or individual wireless access instruments from - laboratories - medical records - X-ray department ǒ There exists a central monitor which monitors the vital signs of all ICU patients at the ICU nurses station.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert "X" as appropriate

STANDARD Indicator	RATING					
5. THERE IS A POLICY FOR ADMINISTRATION OF THE ICU FOR ADMISSION, MANAGEMENT AND DISCHARGE OF PATIENTS: • There is a Consultant Anaesthesist in charge of ICU who makes the ultimate decision about admissions, discharges and management of patients in the ICU. • There is adherence to the ópatient suitability for admission guidelinesô outlined in the ICU manual. • The medical officer from the admitting discipline is present at or soon after admission of his/her patient to the ICU and makes an input where applicable. • There is adherence to the Transfer Policy where applicable. • There is a multidisciplinary approach to the management of patients in the ICU. Decisions made by either the head of ICU or the admitting medical or surgical team are communicated to the others and discussed. • All persons involved in patient management are easily accessible (via phones, pagers). • The referrals to the appropriate specialists are made in a ótimelyô manner. • There is a policy of multidisciplinary determination of brain stem death; however the Consultant Anaesthetist has the final say. • Termination of life support is a multidisciplinary decision.						**REMARKS**

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert "X" as appropriate

STANDARD Indicator	RATING					
	N	A	M	P	S	REMARKS
• There is consultation with relatives prior to the termination of life support. • There exists an internal transfer memorandum of understanding: i.e. bed space availability and/or shared beds between firms. • The following comprise the ICU management team: - An Inventory Manager responsible for the disposable equipment and sundries - A Manager for other ICU equipment, maintenance, storage, cleaning, sterilization and inventory - A pharmacy liaison - A Nursing staff representative (sister in charge) - A Medical Staff Representative (Consultant Anaesthetist) • There are monthly and quarterly administrative meetings. • Reports are generated from meetings and displayed in the ICU and sent if necessary to support services and administration: - Anaesthetics Department - Microbiology Department - Nutrition Department - Laboratories - Radiology Department - Pharmacy Department - Chief Executive Officer - Other Departments if applicable.						

STANDARD Indicator	RATING					
6. THERE ARE SOUND MEASURES IN PLACE FOR	N	A	M	P	S	REMARKS

INFECTION CONTROL AND SURVEILLANCE: • An ICU infection control policy has been developed in conjunction with the consultant microbiologist. • There is a wash basin in each cubicle. • Visitors and staff to the ICU are required to wash their hands on entering and exiting the ICU. • Proper hand-washing practices are enforced. • There is a non-reusable hand-drying facility. • There is an isolation cubicle with an enclosure and isolated ventilation i.e. AC separate. • There are weekly visits by a microbiologist to: - review ICU microbial profile and therapy with the medical and nursing staff - make recommendations on specific patients and - make recommendations on procedures for the collection of specimens and infection control. • Trapped Sputum for culture and sensitivity are collected routinely for each incubated ICU patient at least twice weekly or as recommended by the microbiologist. • Other specimens for culture and sensitivity are collected appropriate to the infected organ system. • Antibiotic regimes are regularly reviewed (at least weekly) for effectiveness as well as patterns of resistance.						

STANDARD Indicator	RATING					
	N	A	M	P	S	REMARKS
7. THERE IS A POLICY FOR THE MANAGEMENT OF VISITORS. • There is visitor selection (a list of visitors determined by the main relative(s) or stakeholder(s)). • There is restriction of the numbers of visitors per patient per instance. • Two relatives are selected to whom and only to whom information is given concerning the patient. • Contact details of main relative(s) are recorded and accessible to staff on call. • Specific personnel are permitted to speak to relatives about the disease process. • There are documented instructions on the following: - when to call relatives - consent for procedures - consent for blood - what to do when patientôs condition worsens - termination of support - death.						

N = Not Applicable A = Absent (0) M = Minimal (1-3) P = Partial (4-6) S = Substantial (7-10) Insert "X" as appropriate

PROVIDING CONDITIONS FOR CARE AND TREATMENT

STANDARD **Indicators**	Organization Rating	N	M	P	S	External Rating	N	M	P	S

1. THERE IS A SAFE AND HEALTHY ENVIRONMENT Å The nursery presents a clean appearance throughout. Å Staff wash their hands on all appropriate occasions. Å There is cleaning schedule for ancillary staff. Å Appropriate methods and cleaning agents are identified for different areas. Å There is an accessible copy of the Health Facilities Infection Control Policies and Procedures Manual. Å The policy from this manual for the storage, collection, transportation and disposal of hospital waste is followed.		

PROVIDING CONDITIONS FOR CARE AND TREATMENT

STANDARD **Indicators**	Organization Rating	N	M	P	S	External Rating	N	M	P	S
Å All baths and sinks in the nursery provide running water 24 hours per day. Å Toilets are clean and functioning.										

2. EQUIPMENT IS PROPERLY INVENTORISED AND MAINTAINED Å There is an equipment inventory which has been updated within the last year. Å There is a list of critical equipment with: ➢ a schedule of preventive maintenance ➢ dates of completed maintenance ➢ dates of unscheduled maintenance Å A monthly list is kept of the number of inoperable pieces of equipment, with records of: ➢ failures of equipment		

PROVIDING CONDITIONS FOR CARE AND TREATMENT

STANDARD **Indicators**	Organization Rating	N	M	P	S	External Rating	N	M	P	S
➢ damage during use ➢ down time ➢ failures in maintenance response										
3. ORIENTATION IS PROVIDED FOR ALL STAFF WHEN THEY JOIN THE DEPARTMENT Å An orientation is provided for: ➢ medical staff ➢ nursing staff ➢ ward assistant/ward clerks ➢ ancillary staff Å There are written orientation guidelines for each of the above categories of staff. Å Orientations are documented.										

4. THERE IS EFFECTIVE ORGANIZATION AND MANAGEMENT OF THE NURSERY		

PROVIDING CONDITIONS FOR CARE AND TREATMENT

STANDARD **Indicators**	Organization Rating	N	M	P	S	External Rating	N	M	P	S
¡ There is a Medical Consultant to manage the nursery. Å There is a Hospital Administrative Policy and Procedures Manual accessible to all staff. Å Job Descriptions exist for all positions. Å Each staff member is given a copy of his/her job description. Å Clinical staff meetings are held monthly. Å All categories of staff attend quarterly staff meetings. Å Staff meetings are minuted and problems which cannot be addressed at the departmental level are taken to meetings of Senior Management. Å There are in-service training programmes for all categories of staff and these are documented.										

AUDIT INSTRUMENT FOR THE INFECTION CONTROL PROGRAMME IN OPERATING THEATRE DEPARTMENT

☐External Audit **☐ Internal Audit** **☐Surveillance Audit**

Health Facility:_____**Audit Date:** _____

Audit Team Members/Monitoring Officer:_____

STANDARD **Indicator**	RATING					
	N	A	M	P	S	REMARKS

PHYSICAL ENVIRONMENT **1. THE PHYSICAL ENVIRONMENT IS CONDUCIVE TO INFECTION PREVENTION AND CONTROL** • All floors in the OR(s) are - hard - seamless a continuous surface - easy to clean • There are no floor drains installed in the OR(s) • All the walls in the OR(s) are free of fissures, open joints or crevices						

STANDARD **Indicator**	RATING					
	N	A	M	P	S	REMARKS

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARD Indicator	RATING					
	N	A	M	P	S	REMARKS
PHYSICAL ENVIRONMENT CONTINUED ⬮ All the ceilings in the OR(s) are waterproof, seamless and easy to clean - There are one or more scrub sink areas with running water from elbow taps for surgical scrubbing ⬮ There is an area to store sterile and/or high level disinfected supplies, instruments and equipment with - limited access to the storage area or closed cabinets - clean, dry, dust-free and lint-free area **2. THERE IS A SYSTEM IN PLACE TO IMPLEMENT, MONITOR AND EVALUATE INFECTION PREVENTION AND CONTROL** ⬮ The Health Facilities Infection Control Policies and Procedures Manual is readily available in the department ⬮ Cleaning schedules for daily and routine cleaning are available ⬮ Monitoring of the Cleaning Schedules is done by the Consultant or Sister in Charge in the department ⬮ Monitoring dates are recorded ⬮ Findings are documented and filed						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARD Indicators	RATING N	A	M	P	S	REMARKS
• Consultant/ Sister-in-Charge assesses whether recommended practices are being adhered to: e.g Traffic flow - Occupational health programme including work exclusion and post-exposure recommendations - Personal protective equipment and surgical attire - Handwashing practices including surgical hand scrub - Instrument and other articles cleaning procedures - Storage of sterile and high-level disinfected instruments - Sterilization process - Maintenance procedures for equipment - Disposal of Sharps - Waste disposal - Housekeeping to include - cleaning before procedures - cleaning during procedures - cleaning between and after procedures - terminal cleaning - scheduling cleaning - Opening and setting up rooms - Perioperative aseptic techniques including but not limited to *Catherization						

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
- *Intravenous technique - *Patient skin preparation - *Gowning - *Gloving - *Anaesthesia - *Draping - *Safety practices for handling, passing and disposing of sharp instruments - *Wound dressing and drains - *Care of specimens - *Waste management - *Other (Specify) _____ - Findings are documented						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
3. THERE ARE ADEQUATE EQUIPMENT AND SUPPLIES FOR HANDWASHING • Handwashing reminders are displayed over wash basins. • All areas have: - running water - soap/soap dispenser - paper towels/hand dryer - Step-on-bins						
4. HANDWASHING RULES FOR SURGICAL SCRUB AREOBSERVED BY ALL STAFF • At the beginning of a procedure the surgical personnel - Removes all jewelry from fingers, hands and forearms - Has clean, short finger nails without nail polish - Washes hands and arms up to the elbows using antimicrobial soap - Cleans under each fingernail using the stick or brush - Washes between all fingers - Moves from finger tips to elbows of one hand and repeats for the other hand - Washes for at least 2-5 minutes						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS Indicators	RATING					
	N	A	M	P	S	REM ARKS
- Uses a separate clean cloth towel for each hand to wipe from finger tips to the elbow and then discards the towel - Holds hands above the level of the waist and away from the body and does not touch anything - Immediately gets into sterile clothes						
5. THE PROPER ATTIRE IS ADHERED TO BY ALL STAFF - Clean surgical cap and face mask covers head and facial hair, including sideburns and necklines are worn behind the red line - Clean appropriate foot wear that will provide protection from fluids and dropped items are worn behind the red line - Mouth and nose covered with a mask when open sterile items and equipment are present and behind the red line						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
6. THE PROCEDURES FOR TRAFFIC FLOW AND ACTIVITY PATTERNS ARE FOLLOWED IN THE TRANSITION ZONE • Traffic is limited to authorized persons only • Personnel enter in street clothes and exit into a semi-restricted or restricted area with proper attire • Staff change in dressing rooms and store clothes in lockers						
7. THE PROCEDURES FOR TRAFFIC FLOW AND ACTIVITY PATTERNS ARE FOLLOWED IN THE SEMI-RESTRICTED AREAS (OUTER ZONE) • Traffic is limited to patients and authorized personnel • There are pre-operative and recovery rooms • Sterile and high level disinfected supplies are stored in a designated area • Personnel wear surgical attire and cover their head and facial hair with a cap and face mask • Personnel wear appropriate foot wear which protect their feet from fluids and dropped items						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
8. THE PROCEDURES FOR TRAFFIC FLOW AND ACTIVITY PATTERNS ARE FOLLOWED IN THE RESTRICTED AREAS (CLEAN ZONE) • There are scrub sinks areas • Patients entering the surgical suite wear clean gowns, are covered with clean linens and have their hair covered • Doors to the OR are always kept closed, except during movement of personnel, patients, supplies and equipment						
9. THE PROCEDURES FOR THE CLEANING OF THE ROOM(S) BEFOR PROCEDURES ARE FOLLOWED • All horizontal surfaces within the operating room are damp-wiped or mopped with a clean, lint free cloth moistened with clean water and detergent or an approved disinfectant cleaning solution: - Furniture - Equipment - Lights - Overhead tracks						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
- Two buckets are used One with water and detergent or an approved disinfectant cleaning solution and the other with clean water for rinsing						
10. THE PROCEDURES FOR THE FLOW OF CLEAN AND SOILED SUPPLIES, INSTRUMENTS, LINEN AND EQUIPMENT ARE FOLLOWED						
⬮ Used and soiled supplies, instruments and equipment are transported in closed containers to outside of the restricted area after use ⬮ Used and soiled supplies, instruments and equipment do not re-enter the sterile core area before being processed ⬮ **S**oiled linen and waste are transported in closed or covered carts or containers to outside of the restricted area						
11. THE PROCEDURES FOR THE DISPOSAL OF INSTRUMENTS, LINE AND WASTE AFTER SURGICAL PROCEDURES ARE FOLLOWED ⬮ Personnel wear gloves when handling soiled instruments, linen and waste ⬮ All waste (e.g., gauze, cotton wool, dressing, etc.) are disposed of in a leakproof container ⬮ Instruments are placed in a 0.5% chlorine solution for 10 minutes ⬮ Needles and sharps are disposed of in a puncture-resistant container						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
⬮ Soiled linen is placed in a leakproof container ⬮ Sterile gloves are removed and disposed in a leakproof container ⬮ Hand washing is performed after removing sterile gloves ⬮ Other disposables generated in procedure e.g. plastic rubber tubings and bags are stored in small receptacles or Step-on-bins ⬮ Above receptacles or step-on-bins lined with yellow or red bags						
12. THE PROCEDURES FOR THE CLEANING OF ROOMS BETWEEN AND AFTER SURGERY ARE FOLLOWED ⬮ Housekeeping personnel wear utility gloves and other personal protective equipment during cleaning. ⬮ All waste is collected and removed from the rooms in closed leakproof containers. ⬮ Puncture-resistant containers are closed and removed when three quarters full ⬮ Containers with 0.5% chlorine solution with instruments are closed and removed from the room. ⬮ Soiled linen is removed in closed leakproof containers - Soiled linen handled as little as possible - Soiled linen placed in clear plastic bags - Clear plastic bags with soiled linen tied when 3/4 full ⬮ Small body fluid spills are contained and cleaned with a disinfectant cleaning solution ⬮ Large body fluid spills are covered with 0.5% chlorine solution for 10minutes, mopped up, and then cleaned with detergent and water. ⬮ All horizontal surfaces that have come in immediate contact with a patient or body fluids are cleaned with a disinfectant cleaning solution.						

N– Not Applicable **A-Absent (0)** **M -Minimal (1-3)** **P- Partial (4 - 6)** **S- Substantial (7-10)** **Insert "x" as appropriate**

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
⬮ Each mop-head is placed in a container after use. ⬮ Two buckets are used - One with the disinfectant cleaning solution - One with clean water for rinsing						
14. THE PROCEDURE FOR THE ROUTINE CLEANING OF THE OPERATING THEATRE AS OUTLINED IN THE DEPARTMENT'S OPERATIONAL POLICY MANUAL IS FOLLOWED						
15. THE PROCEDURE FOR CLEANING AFTER AN INFECTED CASE IS FOLLOWED ⬮ Cleaning personnel wear disposable clothes and shoe covers ⬮ The room, operating table and trolleys are cleaned with 1% bleach ⬮ Non-metallic and non-rubber instruments are soaked properly before washing in 1% bleach ⬮ Instruments are washed, dried and sterilized ⬮ The theatre stretcher used to transport the patient is wiped down with 1% bleach						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
• The linen is bagged in clear plastic bags and sent to the laundry • The waste and body parts are double bagged in red coded bags and tied to be incinerated **16. THE PROCEDURES FOR THE DECONTAMINATION OF THE CLEANING EQUIPMENT ARE FOLLOWED** • Cleaning equipment (eg. mops) is decontaminated by soaking for 10 minutes in 0.5% chlorine solution or other approved disinfectant. - Washed in detergent and water. - Rinsed in clean water. - Dried completely before reuse or storage						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
17. THERE ARE ADEQUATE PROCEDURES FOR THE CLEANING AND DECONTAMINATION OF INSTRUMENTS/FURNITURE: • Soiled instruments are in a separate area/room from clean instruments • The solution for decontaminating is of an appropriate concentration • The staff described the appropriate decontamination process (10 minutes soak, wash and rinse) • Respiratory therapy and resuscitation equipment are sterilised and changed every eight hours or more frequently if necessary • Humidifiers are filled with sterile distilled water at all times • Equipment is disinfected between patient use • Reusable tubing is washed after use and weekly when used continuously						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

STANDARDS **Indicators**	RATING					
	N	A	M	P	S	REMARKS

18. THERE IS A PROCEDURE FOR THE STORAGE OF STERILE OR HIGH-LEVEL DISINFECTED ITEMS • Clean supplies are not stored with sterile or high-level disinfecteditems • Unwrapped items are used immediately and are not stored • Sterile or high-level disinfected packs and/or containers have • expiration dates on them • There is a rotation and an inventory system to control the use of sterile or high-level disinfected items • The packs are free of tears, dampness, dust **19. THERE IS AN APPROPRIATE CLEANING PROCEDURE FOR THE OPERATING THEATRE DEPARTMENT** • Training is available for ancillary staff at orientation and in-service on cleaning procedures for the department • There is a Schedule for daily routine cleaning • There are established cleaning procedures which are strictly adhered to • Proper post patient cleaning procedures performed (cleaning of tables and furnishings with detergent) • Monthly scheduled intensive cleaning of the department is a part of the overall cleaning programme • Ancillary staff wear protective clothing when cleaning the department						

STANDARDS **Indicators**	RATING					
	N	A	M	P	S	REMARKS

20. THE DEPARTMENT PRESENTS A CLEAN APPEARANCE • The health care providersô bathrooms are clean • The Dressing Room is clean • There is the absence of blood, dust and spider web in the following areas - floors - walls - ceilings - windows - OR lamps - stools - sinks for surgical scrub - tabletops and counters - ledges and any other flat surfaces - OR tables						

STANDARDS **Indicators**	RATING					
	N	A	M	P	S	REMARKS
- trolleys - Equipment (oxygen cylinders, suction machines, anaesthesia machines) - storage area - Recovery beds						

STANDARDS **Indicators**	RATING					
	N	A	M	P	S	REMARKS

21. THE HEALTH CARE PERSONNEL FOLLOW THE GOWNING PROCEDURES • All health care personnel wear short sleeved scrub suits or gowns whilst in the department • Gowns and Scrub Suits are opened and tied at the back • Scrub Suits or Gowns are not worn outside the department - Health care personnel temporarily leaving the Unit wear a clean covering gown or laboratory coat over their scrub suits or gowns						

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
- Gowns/Scrub Suits are not shared - Hands are washed before putting on gowns and after taking off gowns - **All soiled Scrub Suits or Gowns are placed in clear plastic** bags for removal to the laundry						

STANDARDS Indicators	RATING					
	N	A	M	P	S	REMARKS
24. THERE IS A SYSTEM IS IN PLACE TO MONITOR THE HEALTH STATUS OF STAFF ASSIGNED TO THE DEPARTMENT • Personnel should have up-to-date immunizations as recommended (See Appendix 1 ï Health Facilities Infection Control - Policies and Procedures Manual) • Personnel with URTIs, GI Tract infections, open lesions or a suspected infection of any kind are referred to a physician and should not work in the unit						

N– Not Applicable A-Absent (0) M -Minimal (1-3) P- Partial (4 - 6) S- Substantial (7-10) Insert "x" as appropriate

MINISTRY OF HEALTH
REGIONAL HEALTH AUTHORITY AUDIT CONFORMANCE RESPONSE
REGION: SOUTH EAST REGIONAL HEALTH AUTHORITY

BUSTAMANTE HOSPITAL FOR CHILDREN

HEALTH FACILITY & SERVICE DELIVERY AREA	NON- CONFORMANCE ITEMS	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
BHC - ICU	The central AC unit is defunct. 3 split units are being used.	**Procurement Issues** ○ To arrange for the procurement of a 100% fresh Air System to address the issues of poor air ventilation from the 3 spilt A/C unit currently being used in the department. **ACTION TAKEN:** Schedule developed for regular cleaning (2 weeks interval)	**ON-GOING**	**IN-PROGRESS**

	There is no ICU Policy and Procedures Manual available within the unit.	○ Obtain a copy of the ICU Policy and Procedures Manual and ensure it is placed in the area. ○ Ensure that user friendly folders are procured for the ICU Policy and Procedures Manual **Action Taken:** Obtained copy of the ICU Policy and Procedures Manual and placed in the area. An order was made to purchase folders for Policy and Procedure Manuals. To check with the Regional Office on: ○ The status of the request made.		**DONE.**
	There are no dedicated ICU beds. The beds from the wards are being used. These however are not able to be tilted and have the necessary changeable positions for efficient patient care and resuscitation.	○ Obtain specification to procure dedicated ICU beds and supervise the procurement of same	**DECEMBER 21, 2015**	**PROCUREMENT: IN-PROCESS**

Cont'd

HEALTH FACILITY & SERVICE DELIVERY AREA	NON- CONFORMANCE ITEMS	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
BHC - ICU	The storage area is congested with the same room serving for counselling, lunch room, overnight room, meeting and storage.	**Infrastructural Issues** Dialogue to be arranged with the Regional Office in regard to:		**DONE**

		○ A redevelopment project for ICU to acquiring additional storage and office space for staff. **Action Taken:** Separation of counselling room and lunch room completed		
	There is no change room or shower for staff	Renovate and improve existing bathroom and construction shower area for ICU staff. **Action Taken**: Renovated		**DONE**
	Lockers are needed for staff to keep their personal items.	**Action Taken**: Adequate lockers were provided.		**DONE**
	Containers for the collection of trapped sputum are not available.	Advised procurement officer to treat containers for the collection of trapped sputum (currently stored in the Pharmacy Stores) as stock items. Ensure stock levels are monitored by Storekeeper. **Action Taken**: Procurement Officer advised and stock levels now being monitored.		**DONE**
	Receive Purchase Order	To check with the regional office on the outcome of previous request made for ventilator for ICU and if necessary, ensure order is resubmitted and treated as items for emergency procurement. **Action Taken:** Checks were made and procurement is in progress.	**November 25, 2015**	
	Additional back-up ventilators are needed.	Action Taken: Procurement were done. Item received on November 5, 2015		**DONE**
HEALTH FACILITY & SERVICE DELIVERY AREA	**NON-CONFORMANCE**	**RECOMMENDED / PROPOSED CORRECTIVE ACTIONS**	**TIMELINES**	**STATUS**

BHC - OT	▪ Access areas are not clearly delineated	**Action Taken**: Specific signage will be installed.	November 06, 2015	**IN-PROGRESS**
	▪ The main storage room is disorganised. This does not facilitate any form of inventory control or the rotation of items to prevent wastage due to items becoming out-dated.	**Action Taken**: Identify team and proposed work day to organise area.	November 30, 2015	**IN-PROGRESS**
	▪ A monitoring schedule for the assessment of Infection control practices is to be prepared.	**Action Taken**: Schedule was developed and a log book was implemented. Planned internal audit	November 30, 2015	**IN-PROGRESS**
	▪ Sterile items are being passed through the sluice room. This is unacceptable.	**Action Taken:** This will be included in the new construction plan for OT.	December 31, 2015	
	▪ There is no monitoring of the health or immunisation status of staff working in the OT suite.	**Action Taken**: Existing staff were advised to obtain and submit document their indicate health status. Going forward new staff will be asked to provide document indicating their health status upon employment.		**IN-PROGRESS**
	▪ Cabinets for the storage of sterile supplies etc are door-less, in different stages of disrepair and scattered in various parts of the O.T suite.	**Action Taken**: Glass was purchased and installed.		**DONE**
	▪ A cleaning schedule is to be developed and documented with clear SOPs for the janitorial staff and PCAs. There is too much individualisation in the preparation of cleaning solutions.	**Action Taken**: Cleaning schedule was developed, laminated and posted in all areas.		**DONE**

	▪ Janitorial staff is not provided with utility gloves and mops of the appropriate quality or quantity.	**Action Taken**: Adequate utility gloves and mops of the appropriate quality or quantity were provided to janitorial staff.		**DONE**
	▪ The OT doors are in a poor state. Hinges are rusted and functioning poorly, windows are broken and some have termites. They all are unable to be properly closed.	**Action Taken:** Hinges were repaired and installed.		**DONE**
	▪ The janitorial staff assigned to the operating theatre requires training in the proper use of the cleaning materials.	**Action Taken:** Training was for proper use of the cleaning materials was done.		**DONE**
	▪ There is need for the overall standardisation of the cleaning and disinfecting solutions to be used in the high risk areas.	**Action Taken:** A measuring instrument is used being for each proportion of chemical to water.		**DONE**
	▪ The recovery room has a leaking roof	**Action Taken:** Roof will be repaired.	**December 22, 2015**	**IN-PROGRESS**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON- CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
BHC – A&E	Cleaning procedures and methods are not in accordance with standards.	Review JACDEN contract to ensure that cleaning procedures and methods are in accordance with Ministry of Health standards **Action Taken**: Reviewed and relevant communications made.		**DONE**
	Chemicals are not labelled and need to be stored away from the children.	○ To meet with current and new Janitors to remind and orientate them respectively on cleaning procedures and methods; ○ To arrange for JACDEN supervisor to do regular spot check (every 45 minutes) of A&E to ensure cleaning procedures and methods are adhered to; **Action Taken**: An alternative storage area was identified to store chemicals and cleaning equipment away from children. To ensure: ○ Proper containers are used to store chemicals and ○ Containers used to store chemicals are labelled correctly. ○ Regular spot checks will be done going forward		**DONE** **DONE**
	Medical records are not being completed according to standards.	**Action Taken** ○ Forms reviewed ○ Monitoring for efficiency		**DONE**

PHOTOGRAPHS OF REFURBISH AREAS AND NEW EQUIPMENT FOR BHC

Hinge in the Operating Theatre Door

Operating Theatre Sterile Cabinet - BHC



ICU Bath rooms - BHC

ICU Sluice Room - BHC

MINISTRY OF HEALTH

REGIONAL HEALTH AUTHORITY AUDIT CONFORMANCE RESPONSE

REGION: SPANISH TOWN HOSPITAL

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
SPTH-A&E	Hand washing guidelines are not being adhered to. Blood is taken without gloves and hands are not washed after removing gloves	**Action Taken**: a. Increased vigilance of team members to remind and ensure that all are compliant with the infection control measures and universal precautions. Signs have been posted in the areas to remind staff. b. Hand sanitizers have been installed and soap dispensers c. In the pre-audit period two medical officers were assigned to conduct training for all categories of staff on hand washing techniques and on compliance with universal precaution in handling blood and other body fluids. These two medial officers left the department which delayed the training. Training is now scheduled for once monthly (3rd Thursdays). d. Hand washing sink and soap dispensers have been installed.	Ongoing next training is scheduled for November 26, 2015	**ON GOING** **DONE** **ON GOING** **DONE**
	Cleaning materials are not labelled. There is no	**Action Taken:**	November 13, 2015	

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	documented cleaning schedule.	a. Appropriate labels procured and will be affixed to the containers. Supervisors from Manpower have been instructed by the Contractôs Monitoring Officer to clearly label all containers containing chemicals. New containers being implemented by the Contractor. Confirmed by the Contracts Monitoring Officer as at November 5, 2015. This will also be monitored by The Accident and Emergency Manager (on a weekly basis) going forward. b. Cleaning Schedule existed (one with manpower staff and one in consultantôs office). These have now been erected and end-user is required to sign off on the time work was done.		**DONE** **DONE**
	The cleaning methods do not conform to standards	**Action Taken:** a. To consult MOH Infection Control Policies and Procedures manual for standard on Cleaning, Disinfection and Sterilization consultation with Dr Karen Shaw Government Microbiologist where necessary and continue to reference international standards (ISO and U.S. standards) b. Infection Control Nurse will be conducting training on cleaning methods for the Janitorial and Portering staff. Training is scheduled for November 6, 2015.	November 6, 2015	**ON GOING** **ON GOING**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	Job descriptions are to be prepared and given to all staff on recruitment	**Action Taken:** a. Director of Nursing has confirmed that all nursing and other non-medical staff are given job description and going forward we will ensure that job descriptions are given at orientation, by the Parish Personnel Manager b. At orientation all Medical Officers (MOs and SHO) are taken through the appropriate MOH Policies and Procedures manual which addresses what is expected (JD) based on level of responsibility. In addition based on availability or unavailability of the appropriate level staff from day to day and based on the area of assignment that job description could change.		**DONE**
	Staff needs to be made familiar with the mass casualty plan and the plan should be tested at least once per year	**Action Taken:** a. All A&E staff (apart from those who joined the department in less than one year) would not only be familiar with the mass casualty plan but would have actively participated in the yearly mass casualty scenarios/drills.	November 30, 2015	**ON-GOING**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
		b. In 2015, with the threat of Ebola the simulation exercise took the form of an Ebola evacuation. c. The mass casualty plan is not only shared with the A & E staff but with the entire hospital family and tested with evaluation of response of all involved d. The Head of Department, is to arrange Mass Casualty exercise for November 2015		
	Wheelchairs and stretchers are in short supply. Patients who are awaiting admission to the wards stay on the chairs and stretchers for extended periods	**Action Taken**: Additional wheelchairs (5) have been obtained since the audit period. Additional stretchers will be repaired and procured	November 7-8, 2015	**IN- PROGRESS**
	Additional wheel-chairs are needed in the department. A number of wheel-chairs are defective with no rubber on the wheels and no footrest.	**Action Taken:** Procurement has started for the purchasing of 25 adult wheelchairs and 5 wheelchairs for children as short term measure.	November 13, 2015.	**IN- PROGRESS**
	Additional stretchers are needed in the department	**Action Taken**: Additional Stretchers have been ordered to handle the overcrowding in the Accident and Emergency department.		**IN – PROGRESS**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	Sharps containers are inappropriate. Cardboard boxes and plastic bottles are used	**Action Taken:** a. Sharps containers were ordered and are expected to arrive at our facility November 13, 2015. b. Directives have been issued to state that with immediate effect no cardboard boxes will be used for sharps.		**IN-PROGRESS**
	Patient bathrooms need to be upgraded. Seats and tank covers were missing in a few places. The staff toilet in the records department did not flush	**Action Taken:** a. Toilet seats covers were bought b. Staff toilet was repaired c. Frequent monitoring of patient bathroom is done There is a challenge with persons stealing the toilet sets each time they are replaced.		
	Orientation guidelines need to be prepared for clinical staff	**Action Taken:** a. Manuals are available to all staff in the Accident and Emergency Department. Manuals are kept in the office of the Nurse Manager, Accident and Emergency Department as well as the office of the Consultant, Accident and Emergency Department.		**DONE**
	No log books are being used. Sheets of paper are used for	Actions Taken		

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	triaging and these are put in the patients records. Therefore no record remain in the department	a. Both Log books and log sheets are being used.		
	A system is needed for the monitoring of the usage of drugs and supplies, in order to prevent stock-outs	**Action Taken:** a. The Nurse Managers assigned to each ward/ department are responsible for ensuring that stock levels are replenished in a timely manner. The current system where the Nurse Manager in charge keeps an account of the drug use complemented by visits by pharmacy technician to reconcile stocks and help to avoid waste due to expiration date is not as effective since some hoarding takes place especially when a particular drug might be in short supply, even with attempts to closely monitor same. The Senior Nursing Managers also conduct ward rounds to check the status of these, twice weekly. b. Pharmacy Department has been charged with the task of doing weekly/monthly audits for all wards and departments to assess the usage pattern as well as evaluate the ñhoardingòof drugs.		**DONE**
	Clinical practice guidelines for commonly seen conditions are	**Action Taken:**		**DONE**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	necessary in order to standardize the emergency care given	a. Manuals and books with various Guidelines for the management of common conditions are readily available in hard copies in the Department. In some cases algorithms are posted in the department and where not posted they are downloaded to and is readily available on the PC desktop for ease of access by all staff members. b. Staffs are advised to consult with the Head of Department and Nurse Manager for the stipulated guidelines.		
Maternity	The containers with cleaning agents are not labelled.	**Action Taken:** a. Labels have been procured; the company has indicated that they will be delivering November 10, 2015. b. Contractor also advised to label all their cleaning bottles which will take effect on the change of shift	November 13, 2015 November 20, 2015	**IN-PROGRESS**
	Mothers are not assigned identification tags.	**Action Taken:** a. Store Keeper responsible for ordering supplies. We are in possession of ID tags which are now being utilized. b. Nurse Manager responsible for requesting same from stores. Blue tags are currently being issued to mothers and white tags for the babies.		**DONE**
	The delivery beds are not the	**Action Taken:**		**IN-PROGRESS**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	appropriate beds	Four (4) delivery beds have been requested, further, the evaluation stage of the procurement process will be done on November 9, 2015.		
	Staff does not wear identification badges	**Action Taken:** All staff is encouraged to wear ID cards, at all times while at work.		**ON GOING**
	A number of items are in short supply or are absent	Action Taken: Items such as fleet enema etc have been procured In terms of Facilities for sitz bath - instructions are given to patients on how to properly perform this bath at home)		
	Discharge summaries remain delayed completion	Actions taken Subsequent to the Audit, Medical Records have reported an improvement in the completion of discharge summaries. Consultants and SR task with responsibility to ensure that summaries are done before they complete the rotation. Improvement in our staff compliment is also needed especially in the orthopaedic and surgical disciples.		SMO ensure that requisite officer complete this task .

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	Orientation guideline need to be prepared for the clinical staff	**Action Taken:** a. Director of Nursing has confirmed that all nursing and other non-medical staffs are given job description. Going forward this will be prepared and given at orientation, by the Parish personnel Manager. Each Department is furnished with the MOH policies and Procedures Manual. Nursing also has an Active In-Service Coordinator tasked with the responsibility of carrying out this function. b. At orientation all Medical Officers (MOs and SHO) are taken through the appropriate MOH Policies and Procedures manual which addresses what is expected (JD) based on level of responsibility.		**ON GOING** **ON GOING**
Nursery	The containers with cleaning agents are not labelled.	**Action Taken:** a. Labels have been procured; the company has indicated that they will be delivering November 10, 2015. b. Contractor also advised to label all their cleaning bottles this will effect on the next shift change	November 13, 2015 November 20, 2015	**IN-PROGRESS**
	The cleaning methods do not conform to standards and schedules are not documented	Action taken: a.Cleaning schedules do exist however same has been		Cleaning methods have been revised.

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
		revised in terms of the methods b.Post cleaning schedules		Cleaning schedule have been posted
	Makeshift sharp containers are being used. These present a risk to staff	**Action Taken:** a. Procurement has been made for appropriate sharps containers and we await delivery. b. With immediate effect no cardboard boxes will be used for sharps.	November 13, 2015	**IN-PROGRESS**
Nursery	The storeroom has a number of non-functional equipment. These needs to be removed so that the spare beds for the nursery can be stored there instead of a space on nursery ward.	**Action Taken:** a. The room was emptied and is now used as recommended		**DONE**
	Excess furniture in the clinical area hampers the proper cleaning of the floor	**Actions Taken:** Cupboards removed which was being utilized by Medical Records		**DONE**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	Food and drug are not to be stored in the same refrigerator. This affects the cold-chain management of the drugs. A refrigerator is needed to store the staff food and drink	**Action Taken:** a. Refrigerator Procured and is now in the department. We have separate refrigerators for Medication and one for staff members. The Refrigerator for staff members have been place in the staff lunchroom.		**DONE**
	Hand-towels are in short supply hence expensive gauze is being cut for hand drying. This is ῞pennywise and pound foolishò	**Action Taken:** Additional hand towel has been ordered to ensure that adequate quantities are available for distribution. Hand Towel dispenser are being ordered along with sanitizer dispensers. The practice of using gauze has been discontinued, as per the directive issued.		
Nursery	On the day of the audit a Gram-negative organism outbreak was reported in the nursery and there was said to be an absence of the appropriate antibiotic required for the treatment of the babies.	**Action Taken:** a. On the day of the audit there were a few neonates with infections; however, this did not constitute an outbreak		**DONE**
Operating Theatre	The tiles on the walls do not allow for adequate cleaning	**Action Taken:** Deep Cleaning done once weekly, however the area will		**IN-PROGRESS**

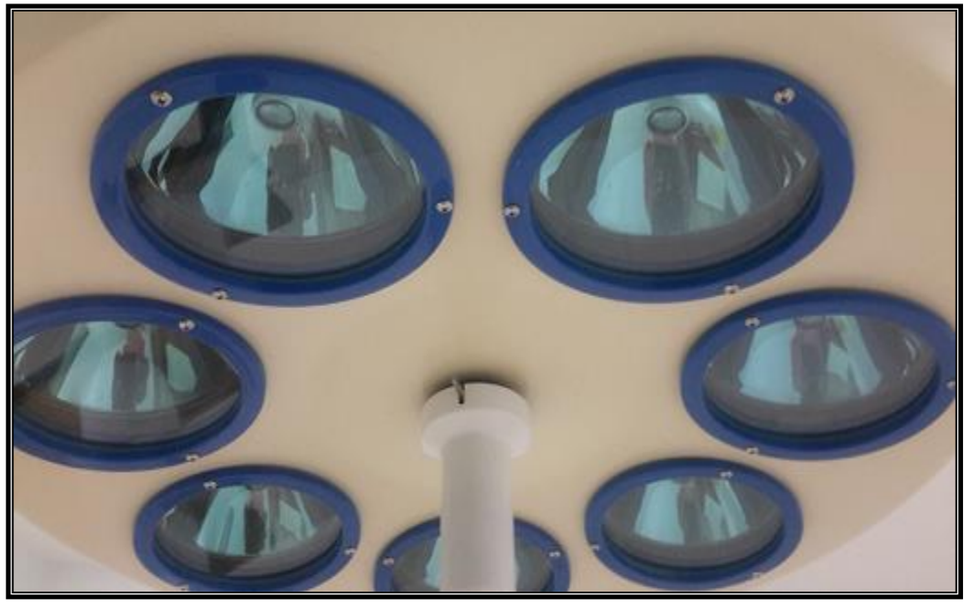
HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
		require re-tiling with larger tiles. This will be done during the refurbishing exercise which will commence the of week November 9, 2015.		
	The Operating Room is crowded with boxes, supplies and unused equipment. These all hamper proper cleaning of the area,	**Action Taken:** The items deemed as unused equipment are actually attachments for the operating table when used in conjunction with a C-Arm. If Items are removed they may go missing. We will place items in a storage container that can be shifted around to facilitate cleaning of the area.		
	The Operating Lights are dull in intensity	New operating Lights are needed as per the Biomedõs assessment. Same has been referred over to Projects. Same will also be addressed at during the refurbishing exercise.	November 2015	
	There is ñFungusò growing between the panes of the glass in the window of the operating room.	The Operating Theatre suite will commence with refurbishing exercise, effective Monday 9, November. Emergency surgeries will be accommodated in the renovated Minor Operating Theatre until all works are completed		
	There is no documented cleaning schedule or documented evidence of monitoring of the cleaning activities.	There are schedules available for the area, same will also be displayed after the renovation exercise		

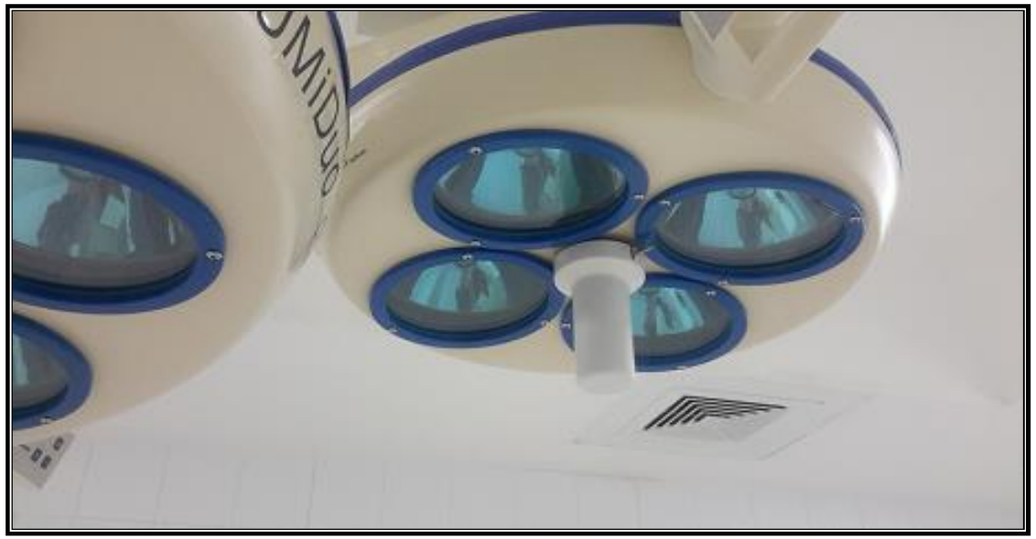
HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	The storage areas are without Doors and are scattered in different areas of the Operating Theatre	To be addressed during renovation period.	November 2015	Refurbishing of Minor OT to be completed first week in November 2015.
	The delineation of access areas needs to be made clear. Infection is being compromised.	Due to the current configuration of the Theatre the delineation of the access areas have not been done. However we will address this issue during the renovation.		
	The disposal of waste from the theatre requires an urgent review and reorganization bins with dirty linins etc are left in the sluice room overnight and removed in the morning through the operating theatre	Review to be done **Action Taken:** Review was done. A skip was placed outside of the sluice room.		DONE
	The segregation of linen needs to be implemented. Soiled linen is put in the open bin with dry dirty linen and the correct colour bags are necessary.	**Action Taken:** Contracts Monitoring Officer has spoken with the Site Manager, Manpower and Maintenance Services. Usage of the correct bags was implemented. Segregation will be implemented on the change of shift. Change of shift is schedule for Friday November 20th, 2015	November 20th, 2015	In-progress
	The expiry date is not affixed to the sterile packs. The date	**Action Taken:**		DONE

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	of sterilization is used. This is not the policy	Expiration dates are now recorded on all packs		
	There is no logbook for supplies sent to the CSSD	**Action Taken:** Log book will be re-implemented	November 6, 2015	DONE
	The opening of the unused chimney in the roof of the sterile room needs to be closed off.	**Action Taken:** This will be addressed during the refurbishing exercise of the Operating Theatre.	**November 2015**	**Refurbishing to commenced November 9-10**
	The carbolic soap being used for hand scrubbing needs to be removed if the antimicrobials are now to be used.	**Action Taken:** The use of Carbolic soap has been discontinued. Antimicrobials are now to be used		DONE
	Material safety sheets for the disinfectants need to be made available to the staff.	**Action Taken:** Operations Manager is in the process of obtaining Material safety data sheet	November 13, 2015.	In- Progress
	Janitorial staff requires training in the correct methods of cleaning and the materials and concentrations of chemicals to be used.	Infection Control Nurse conducted training on cleaning methods for the Janitorial and Portering staff. This training was done on November 6, 2015.		Done

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
	The mops being used are not of the required standard and the number of mops and buckets provided are inadequate.	Number of mops and buckets used for cleaning to be increased. Action Taken: The number of mops and buckets used for cleaning has been increased.		DONE
	The workload in the theatre is enough to warrant the assignment of a secretary/ records officer.	A Medical Records Clerk has always been assigned		DONE

PHOTOGRAPHS OF REFURBISH AREAS AND NEW EQUIPMENT FOR SPTH – Minor Operating Theatre to be used when main OT is closed for refurbishing





REGIONAL HEALTH AUTHORITY AUDIT CONFORMANCE RESPONSE

REGION: PRINCESS MARGARET HOSPITAL

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
Princess Margaret Hospital				
A&E	Cleaning of patientsô bathrooms need to be more closely monitored.	Check List to be developed for monitoring **Action Taken:** Checklist was developed and is being used. Closer monitoring of the area is being done.		**DONE**
	There is no cleaning schedule available.	Cleaning schedule to be developed and posted; Full time Infection Control Nurse to be assigned Action Taken: Cleaning schedules have been developed, laminated and posted in the relevant areas. NB**. An infection Control Nurse is in place but does other duties. (Full – Time Nurse – January 2016)**	January 2016	**IN-PROGRESS**

	Incorrectly coloured bags are used for the disposal of the different categories of waste. This has implications for staff safety.	Red bags are to be used for hazardous waste and is to be placed in red bins, black bags are to be used for regular waste **Action Taken:** The correct colour bags are being used in the respective bins and monitoring to ensure same is being adhere to.		**DONE**
	No list for the inventory of equipment was available.	Inventory list of equipment to be made available **Action Taken:** Inventory list has been updated and posted in the department. The list was previously removed to facilitate painting of the A&E area.		**DONE**
	Documentation in the patient records was not in keeping with the required standards	Documentation in patients records must be in keeping with required standard **Action Taken:** Required standard will be met with the availability of sufficient space as well as the introduction of the EPAS when the A&E expansion is completed.	Dec. 1, 2016	
	Cards are being used to record patient information.	Dockets are to be used to record patients information **Action Taken:** With the pending expansion of the A&E this will be address. Using of causality cards is the old system..	Dec. 1, 2016	

	The orientation of staff is not structured.	Orientation for all staff must be structured **Action Taken:** The nursing department has a structured orientation programme. The nursing policy manual orientation checklist is utilized (Page 54 Nursing Policy Manual 2008). HEART/NTA will be contacted to work with Operations and HR to develop a training schedule for the attendants	Nov. 30, 2015	
	Quarterly staff meetings are held but it is not mandatory for all staff to attend	All staff should be mandated to attend staff meetings **Action Taken:** Each department conducts meetings monthly or bi-monthly. Meeting for A&E staff was convened on October 14, 2015. General staff meeting has been convened January 2015 and July 2015.		**DONE**
	Customer services personnel are in place but there is no system to advise patients that this service is available.	System need to be in place to advise patients that customer service is available **Action Taken:** Customer Service Officer can be identified by the vest that they wear. Sighs regarding Client charter of rights displayed	Immediate	

	There is no Quality Assurance Committee.	Quality Assurance Committee is to be put in place **Action Taken:** The Quality Assurance Committee has been established and is slated to have its first meeting on November 20, 2015.		**DONE**
	Protocols in existence are not communicated to staff.	Existing protocols must be communicated to staff **Action Taken:** Policy manuals and protocols are now available in the unit for the staff to utilize. Discussing protocols will be a part of the monthly and quarterly meetings going forward. Infection control manuals are available at each service area.		**DONE**
Maternity Ward	Cleaning schedule was not documented.	Cleaning schedule to be documented and affixed in the relevant areas **Action Taken:** Cleaning schedules has been developed, laminated and posted in the MONIA and other areas. Thorough cleaning of this ward will be done on a monthly basis. The 10p.m. to 7a.m. shift will do thorough cleaning of the delivery room daily.		**DONE**

	Delivery beds are not ideal.	The appropriate delivery beds are to be used **Action Taken:** The mattresses previously used in the delivery room were the incorrect ones. Subsequently two (2) mattresses were procured for the delivery room. The beds were thoroughly cleaned and are washed each Sunday.		**DONE**
	Stethoscopes and sphygmomanometers are not available.	Stethoscopes and sphygmomanometers are to be made available. **Action Taken:** Sphygmomanometers have been repaired. Additional 12 units are being procured	Dec.1, 2015	**IN-PROGRESS**
	Use of partograph.	Partograph need to be used **Action Taken:** Senior Resident to conduct series of training regarding the use of the partograph.	Nov. 13, 2015	**. IN-PROGRESS**
	Patients are not given identification tags.	Patients must be given identification tags **Action Taken:** Identification tags are always available and are placed in each admission pack. Nurses are being reminded that it is mandatory to affix same to patients.		**DONE**

	The system for security needs to be reviewed.	To keep the back door closed. Review current Security system **Action Taken:** Alarm to be installed for long term measure.	Nov. 9, 2015	**IN-PROGRESS**
Operating Theatre	The recovery room has no Recovery Room beds. Stretchers are used. This is not suitable for post-operative care.	Recovery room beds must be used for post-operative care. **Action Taken:** Awaiting specifications to finalize procurement process.	Nov. 13, 2015	**IN-PROGRESS**
	The anaesthetic machine in one of the Operating Rooms is not working**.**	Anaesthetics machine is to be repaired **Action Taken:** The machine has been repaired and is functioning.		**DONE**
	Patient monitors are not functioning.	Repairs to be done in addition to purchase new ones **Action Taken:** Patient monitors have been assessed by the Biomedical Team and stand alone ones have been repaired		**DONE**
	The Operating Theatre doors all need to be repaired or replaced.	Operating theatre doors are to be repaired or replaced **Action Taken:** Assessment was done as part of a comprehensive project regarding replacement of OT doors across the Region. Project spare headed at the Regional level and is expected to be completed by January 2016	January 2016	**IN- PROGRESS**

	The theatre light has missing bulbs and its suspension is faulty making focusing difficult.	Missing bulbs are to be replaced in theatre light **Action Taken:** The bulbs have been replaced and the light is functioning.		**DONE**
	The transportation of waste from the sluice room needs to be reverted to the original process of using the stairs at the back of the OT.	Back stairs at OT will be used for transporting waste from sluice room. **Action Taken:** The stairs at the back of the OT is now being used when taking out the waste.		**DONE**
	Hand washing reminders are required.	Affix hand washing reminders in theatre **Action Taken:** Hand washing reminders have been laminated and posted in the OT		**.DONE**
	The central air conditioning unit is out of service and the split air conditioning units fluctuate in function.	Replace compressor **Action Taken:** Compressor is now procured to repair the unit in the interim. Request will be made for a new central unit.	Nov., 20, 2015	**IN-PROGRESS**
	Cracks in the floor of the operating room limit intensive cleaning as the water affects the laboratory beneath.	Long term to close the Operating Theatre to do comprehensive repairs. **Action Taken** Short term frequent swabbing to floor by infection control nurse will be done	Nov., 13, 2015	**IN-PROGRESS**

	The water pipe runs along the cove of one of the ORS. This limits proper infection control.	Reroute water pipe **Action Taken** This issue will be addressed when the Operating Theatre is expanded (2017/2018). In the meantime swabbing will be done for infection control.	2017/2018	**IN-PROGRESS**
	No bathroom is in the Operating Theatre area for patients	Bathroom is to be provided in OT for patients **Action Taken** This will be addressed in the Operating Theatre expansion project	2017/2018	**IN-PROGRESS**
	The changing room for patients is inadequate and inappropriate.	Adequate and appropriate changing room is to be provided for patients **Action Taken:** This will be addressed in the Operating Theatre expansion project	2017/2018	**IN-PROGRESS**

REGIONAL HEALTH AUTHORITY AUDIT CONFORMANCE RESPONSE

REGION: KINGSTON PUBLIC HOSPITAL

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
Operating Theatre – KPH	The Operating Theatre (OT) doors all need to be repaired or replaced.	To replace operating theatre doors on a phase basis **Action Taken**: Two (2) doors were replaced and the remainder will be addressed based on comprehensive project at the Regional Level.	December 2015 - January 2016	**IN-PROGRESS**
	The light in Operating Theatre 1 is pale, while there are missing bulbs for the one in Operating Theatre 2. The light in Operating Theatre 3 is in need of repairs.	To replace lights **Action Taken**: Two Complete Lights were purchased and awaiting installation by supplier. The process has to be co-ordinated along with the OT team to facilitate the installation. OT will to be closed for three (3) days to facilitate the removal and replacement of the ceiling beds	November 2015	**. IN-PROGRESS**
	Hand washing reminders are required.	To display Hand washing Instruction Posters **Action Taken:** Hand washing Instruction Posters are completed and signage now erected.		**DONE**
	The central air conditioning unit is out of service and the split air conditioning units fluctuate in function.	Ensure continuous servicing of air conditioning unit. **Action Taken:** Frequent monitoring, ongoing servicing and daily		**IN-PROGRESS**

		temperature checks are being done. A new unit is to be procured to reduce downtime if there is a unit failure. There is no split unit in the operating theatre. There is a long-term plan to change the Central Air Conditioning Unit and it is now in the preparatory phase. When the OT is closed for installation the opportunity will be used to implement other corrective measures		
	Ceiling tiles in the scrub area are discoloured or missing.	Ensure replacement of ceiling tiles **Action Taken:** The ceiling tiles were replaced.		**DONE**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
A & E - KPH	The containers with the cleaning agents are not labelled.	Ensure container with the cleaning agents is labelled. **Action Taken:** Cleaning agent containers labelled.		**DONE**
	Job descriptions are to be prepared and given to all staff upon recruitment.	Ensure Job Descriptions are given upon assumption of duties because it is instituted in the whole orientation process. **Action Taken:** Job Descriptions given upon assumption of duties.		**ONGOING**
	Staff need to be made familiar with the mass casualty plan and the plan should be tested at least once per year.	Ensure staff members are familiarized with Mass Casualty Plan at least once per year. **Action Taken:** Mass Casualty Management Planning is incorporated in weekly A & E Unit meetings. Staff members provided with soft copy of the current plan.		**ONGOING**
	Additional wheel-chairs are needed in the department as patients sent to the wards for admission tend to remain in the wheelchairs until a bed is allocated. Effectively reducing the wheelchairs available for use in the A&E department.	Ensure adequate numbers are in circulation. **Action Taken:** Additional wheel-chairs available.		**DONE**
	Additional stretchers are also needed in the department.	Ensure additional stretchers are available in the department		**DONE**

		Action Taken: Additional stretchers procured. Procurement ongoing.		
	The patient lavatories lack seats, toilet tissue and hand-drying facilities. It was reported that the toilets tend to be damaged by the patients. As such a system of securing the facilities needs to be implemented, while ensuring Infection prevention and control is maintained.	Ensure patient lavatories are properly equipped with seats, toilet tissues and hand-drying facilities so that infection prevention and control measures are maintained. **Action Taken:** Hand dryers are being procured. The toilet seats are being replaced.		**ON GOING**
	A system is needed for the monitoring of the usage of drugs and supplies, in order to prevent stock-outs	Ensure strengthening of current system for monitoring the supplies **Action Taken:** Monitoring tool used by A & E Manager on a weekly basis.		**DONE**
	The development of a portering procedure manual and training are essential to ensure the safe transportation and handling of patients.	**Action Taken:** The Portering Procedure Manual is embedded within the contract and has been circulated to the various areas. Training is continuously done by the A & E Consultant, Sister and Manager. This will be reported on going forward.		**DONE**
	Clinical practice guidelines for commonly seen conditions are necessary in order to standardize the emergency care given.	**Action Taken:** Head of A& E Department is currently working on the protocol manual.		**IN-PROGRESS**
	Death review meetings and quarterly internal audits need to be institutionalized.	**Action Taken:** Morbidity and mortality reviews are done quarterly. The absence of autopsy reports continues to presents limitations in having a complete review of Morbidity and Mortality on this quarterly basis.		**DONE**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
ICU - KPH	The blood gas machine is non-functional.	Urgent repairs to be done **Action Taken:** Repairs were done. Machine is currently functioning satisfactorily		**DONE**
	Transducers are required for the monitors.	Procurement to be done **Action Taken:** Procurement was done to ensure that adequate stock is in place at all times for delivery in December 2015.	December 2015	**DONE**
	Hand-washing is not enforced. Hand sanitizer is rarely being used and there are no hand-washing guidelines above the stations.	Measures to be enforced Action Taken: Signs are now in place. Persons are being reminded and encouraged to follow hand washing protocol. Hand		**DONE**

		sanitizer dispensers are ordered and will be installed upon arrival however the bottled ones are currently being used in the interim.		
	The Microbiologist does not visit for regular checks to review the microbial profile and therapy with staff.	**Action Taken:** Previously done routinely, however, at NPHL, limited reagents to test specimens more regularly		**IN- PROGRESS**
	Containers for the collection of trapped sputum are absent. There are no containers available.	**Action Taken:** Records showed that containers were available In Stock. Since January 2015, a special request was made by the A&E Consultant and since then, adequate stocks have been available within the stores		**DONE**
	Additional examination lamps are required.	**Action Taken:** Adequate Lightings are now available		**.DONE**

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTION	TIMELINES	STATUS
VJH -LABOUR WARD -	The cleaning materials and methods do not conform to the MOH standards	Activity to be revisited and cleaning methods reviewed by infection control team. **Action Taken:** The cleaning method was reviewed by the Infection Control Team and the cleaning materials inspected by Public Health Inspectors. Copies of the methodology have been re-circulated to the MONIA areas and same will be extended to other areas. Re-circulated when necessary		**DONE**
	The Labour and Delivery Suite need to have dedicated janitors - there are confidentiality and privacy issues	**Action Taken:** Contractor was met with and request was made to have dedicated staff assigned to this unit. Contractor committed to assign dedicated staff to the area in addition to providing continuous training.		Done

	More oxygen cylinders are required for the wards and the cylinders that exist need to be anchored to prevent injury to the staff and patients in the event of a mishap	Long term, piped oxygen. Comprehensive assessment to be done. **Action Taken:** The structures to secure most of the cylinders are in place. The aim is to fully equip the area with piped oxygen. Technical assessment to be competed	4th Quarter 2015/16 financial year	In-Progress .
HEALTH FACILITY & SERVICE DELIVERY AREA	**NON-CONFORMANCE**	**RECOMMENDED / PROPOSED CORRECTIVE ACTIONS**	**TIMELINES**	**STATUS**
LABOUR WARD -VJH	There is one Resuscitaire in the delivery room. On occasions more than one child has to be on the tray	Ensure adequate Resuscitaires are available in the delivery area. **Action Taken:** Two (2) new Resusitaires are being procured and the other three (3) will be repaired and put back in circulation by November 30, 2015.	November 30, 2015	In -Progress
	There is one foetal monitor which has to be shared by mothers in the first stage room	Ensure foetal monitors are available. **Action Taken:** Two (2) are now available in the area and additional ones to be procured.		Done
	There is one pulse-oximeter for the entire Labour Ward and Delivery Suite	Ensure adequate pulse-oximeter is available at the area. **Action Taken:** Additional pulse-oximeter has been acquired.		Done

	Adequate wheelchairs are on the Labour and Delivery Suite but there are no dedicated stretchers	Stretchers are available for both areas. **Action Taken:** Due to space availability the dedicated stretcher is housed at the OT Complete		Done
	New delivery beds have been acquired however the upper l of these beds have mattresses which are fixed and therefore are unable to be adequately cleaned. Macintoshes are required to cover and protect these new beds	Ensure proper bed coverings are in place. **Action Taken:** Disposable wrappers purchased and are being used to protect the beds from body fluid.		Done
	There are no permanent screens in the first stage room and in a case where a delivery is imminent there is no possibility of privacy. Additional mobile screens are necessary	Ensure mobile screens are procured and awaiting delivery from supplier. **Action Taken:** Procured and awaiting delivery from supplier before the end of November 30, 2015.	November 2015	In-Progress
	There are no emergency buzzers or form of communication for the patients to alert the clinical staff. "shouting" is the mode of alert.	Ensure assessment regarding appropriate system to be implemented. **Action Taken**: Assessment done. Implementation schedule for 3rd Qtr of the fiscal year 2015/2016.	3rd Quarter 2015/16 fiscal year	In- Progress
NCU-VJH	There is no schedule available	Ensure schedule is available **Action Taken**: Schedules are now available.		Done

	The cleaning materials and methods do not conform to the MOH standards	To review by the Infection Control Team and the cleaning materials inspected by Public Health Inspectors. **Action Taken:** The cleaning method was reviewed by the Infection Control Team and the cleaning materials inspected by Public Health Inspectors. Copies of the methodology have been re-circulated to the MONIA areas and same will be extended to other areas.		Done
	There was no copy of the Health Facility Infection Prevention and Control Manual	Ensure circulation of manual **Action Taken:** Infection Prevention and Control Manual was re-circulated at the Unit		Done
	The inventory for the equipment is kept solely by the Materials Management unit	Ensure full compliance of all Inventory procedures. **Action Taken**: Inventory of equipment is kept by the Material Management Unit of the Hospitals. A location record is placed in all units and this document provides for identification of fixed asset.		Done

	There is no system to monitor the usage pattern of essential drugs and supplies. This is important in order to facilitate supplies management	Ensure strengthening of current system for monitoring the supplies **Action Taken:** A monitoring tool is used by Operations Officer on a weekly basis	Ongoing	Done
HEALTH FACILITY & SERVICE DELIVERY AREA	**NON-CONFORMANCE**	**RECOMMENDED / PROPOSED CORRECTIVE ACTIONS**	**TIMELINES**	**STATUS**
	There is no auditing process in place	**Action Taken**: Clinical audits are done. In addition all Still Birth and Neonatal Death are reviewed on a monthly basis by the SMO and the medical staff.		Done
	Staff is unaware of the Client Complaint Mechanism	**Action Taken**: Continuous staff sensitization regarding the Client Complaint Mechanism will be done bi-annually.		In-Progress
	No death review meetings are held	**Action Taken**: Subsequent to the audit, death reviews are being held monthly.		Done
	There is a shortage of sharps containers	**Action Taken**: Sharp containers are in stock Replenished based on reorder level		Done

	The Resuscitaire is defective. One side is absent which may result in a child falling to the floor.	To acquire additional Resusitaires. Defective ones to be repaired. **Action Taken:** Two (2) Resusitaires acquired. Defective one to be repaired was assessed by supplier.	December 2015	In- Progress
	There is one physiological monitor for the entire unit	**Action Taken:** The unit has six (6) monitors. Two are for repairs. The two for repairs are still under warranty. Company did assessment regarding repairs to be done.		Done
	There are three (3) suction machines - none are functional. One portable unit is being shared amongst babies	**Action Taken**: Three (3) suctions machines are now functional and additional machines are being procured.		Done
	The fire exit needs a ramp to facilitate the easy removal of cots and equipment in an emergency. Currently there is only the stairway	**Action Taken**: The Jamaica Fire Brigade met the KPH/VJH team and did an overall assessment of both institutions. We are awaiting the report. Escape route to exit the building via the staircase and assemble point identified at the main care park.	December 2015	In-progress

HEALTH FACILITY & SERVICE DELIVERY AREA	NON-CONFORMANCE	RECOMMENDED / PROPOSED CORRECTIVE ACTIONS	TIMELINES	STATUS
OPERATING THEATRE - VJH	There is a shortage of theatre clothes in the FCU theatre.	Ensure adequate linen is available **Action Taken:** Adequate supplies of linen now available; going forward daily monitoring will be done		Done
	The bathrooms need urgent attention. Nursing staff and patients are using the same facilities in the FCU.	Ensure Staff bathroom is separate from patientsô bathroom **Action Taken:** Staff bathroom is now separate from the patientsô bathroom		Done
	Storage of sterile supplies is in uncovered areas. In addition a trolley is used for additional storage.	Ensure sterile supplies are covered **Action Taken:** OT supervisors ensure trolleys are covered. A permanent solution will be implemented when the impending refurbishing of the unit is being undertaken. (PROMAC Project)		In-progress
	There is no specific assignment of personnel to assess the adherence to infection control practices.	Ensure specific personnel are assigned to do ongoing assessment and adherence to infection control. **Action Taken:** This Unit is jointly managed by KPH & VJH both units now share infection control personnel. Discussions were held and any gaps in the protocol were addressed.		Done

	The access areas are not clearly identified. Hence traffic flow is not monitored or restricted as it should be.	Ensure clearly defined traffic flow for easy accessibility of the areas. Signage to be placed to denote access areas **Action Taken:** Signage will be placed to denote access areas after completion of the refurbishing exercise. (PROMAC Project)	PROMAC PROJECT SHOULD BE COMPLETED TENTITIVELY BY MARCH 2016	In-progress
	Anaesthetists are resisting the wearing of facial masks in the operating room	**Action taken:** Taken : The group is mandated to wear facial masks		
	The janitorial staff need to be given training on the proper mixing and use of the cleaning materials	Ensure proper mixing and use of the cleaning materials **Action Taken:** Training continues in collaboration with Public Health Inspector and Infection Control Team		On going
	The timely removal of waste from the outer corridors needs to be organised to be in tandem with the heavy patient load.	Ensure timely removals of waste from the outer corridors are in tandem with heavy patient load. **Action Taken:** Timely removal of waste is currently being practiced		Done
	Contractors have provided utility gloves for the janitors.	Ensure Contractors provided the gloves for janitors **Action Taken:** The utility glove cannot be use in all activities carried out by the team and as such regular gloves have been recommended to the Contractor as the need arises		.Done
		Ensure standard antiseptic solution is used **Action Taken:**		Done

		Continuous monitoring is being done by the Infection Control Team to ensure compliance		
	The health and immunisation status of the staff is to be monitored according to the recommended schedule.	Ensure health and immunization status of the staff is to be monitored according to the recommended schedule. **Action Taken:** Continuous education and sensitization of staff on the importance of immunization for health care workers. Staff. Process will be introduced to newly employed staff during orientation.		On Going

PHOTOGRAPHS OF NEW OT DOORS KPH AND REPLACEMENT OF CEILING TILES VJH

New Operating Theatre Doors-KPH

CEILING TILES REPLACED IN SLUICE ROOM – LABOUR WARD