



# Society for Quality in Healthcare in Nigeria (SQHN)

# SECOND EDITION ACCREDITATION STANDARDS

## New and Modified Standards

## Preamble

As part of our commitment to strengthening healthcare quality and patient safety in Nigeria, the Society for Quality in Healthcare in Nigeria (SQHN) has updated its Accreditation Standards.

This document introduces new standards as well as modifications to existing ones, reflecting recent developments, field insights, and alignment with international best practices.

It includes:
- Newly developed standards and requirements that address emerging quality and safety priorities;
- Revised standards that offer improved clarity, relevance, and ease of implementation.

Each section is organized by chapter and includes the chapter name, intent statement, standards, and specific requirements.

# PATIENT CENTERED STANDARDS

## PATIENT CARE (PC)

### Overview

A care that is responsive to and respectful of the preferences, needs and values of patients is a patient-centred care.

Provision of healthcare is all about patients and their needs and meeting those care needs in the healthcare facility.

Care of patients is the main reason for every healthcare facility. There must be high levels of planning and coordination in providing the most appropriate safe care, the unique needs of each patient must be identified and responded to appropriately.

**Patient-centred care includes:**

● Involving patients and their families in the decision-making processes of their care;

● Communicating all aspects of the care to patients and their families;

● Treating patients and their families with respect, dignity and empathy;

● Multidisciplinary approach in the delivery of care that fosters collaboration with patients, families and all health care providers.

A patient centred care should result in improvement in health outcome, quality of care provided, and patient satisfaction which in turn results in cost effectiveness.

### PC1.1: Equitable access to care

### Intent

Healthcare organisations promote equitable access to care through service design which is dependent on the information provided by the patients, to ensure that available resources are utilized fairly to meet their needs.

It is therefore important that the organisation identifies the access needs of the population it serves and meets these needs in accordance with relevant legislation. The care provided to patients is integrated, coordinated and there is adequate and clear planning for

discharge, referrals and follow up. The organisation makes available to the public clear and relevant information about services available to them and how to access it.

Requirements:

The organisation shall provide every patient (and family, as appropriate) with standardized Admission Information - details of services offered, visiting hours, billing, patient rights & responsibilities and emergency contacts.

The organisation shall ensure that all patients receive admission information upon arrival, including any required consent or acknowledgment forms. Patients shall be asked to sign these documents, and the signed copies must be retained as part of the patient's medical record.

## Assessment and Reassessment of Patients (ARP)

### Overview

Patients' assessment and reassessment is an integral part of the care of patients. It is important to collect a detailed history and to carry out a full physical examination at initial contact with the patient to be sure that there are no medical risks that would predispose the patient to a medical emergency in the course of their care.

Assessment of patients helps to determine care needs of patients at every point, whether it is emergency or continuing care.

Appropriate assessment would be done for patients based on their age, condition, health needs and preferences or requests for better clinical outcome and patient satisfaction.

Information obtained from the medical history will be the basis for the risk assessment, and it is important that the healthcare provider spends time talking with the patient. The information that may be gathered in the patient history includes:

Presence of systemic diseases

Previous hospitalizations

Previous surgeries

Previous anaesthetic events (how did the patient fare?)

Allergies

Medications

Patient's family history for illness

Social history

Alcohol, drug or tobacco use

It is important that various disciplines involved in the care of the patient work together for effectiveness.

**ARP 2.1** : **Collection of Patient Information or data and application to patient care.**

**Intent**

Patients' experiences are a product of the hospital's systems and processes and ways health providers relate with them. The initial assessment (information) of a patient determines the primary outcome, it is therefore important that the organisation determines the content of an initial assessment of a patient bearing in mind their needs, condition, age and requests or preferences.

Qualified individuals (e.g. doctors) are responsible for the assessment and reassessment of patients. In an emergency, patients' assessment is based on their immediate needs and condition.

Assessment of patients must be done rapidly and completed as soon as possible so that treatment can be initiated; the organisation ensures completeness of assessment by healthcare providers within 10 hours of admission.

Patients' progress is monitored throughout their stay in the hospital through daily reassessment. It is important that there is easy access to these records for those responsible for patient's care and other practitioners for proper coordination and continuity of care.

All patients that require an invasive procedure such as surgery would have their assessment done prior to the procedure and this is documented in a uniform or specified location in the medical records. Diagnostic tests and reports are also readily available in patients' record to assist in the assessment of patients when required.

Patients with long term conditions e.g. chronic kidney disease, hypertension, depression, diabetes, HIV are assessed for risk to protect patients from unintended consequences of care or treatment and identified risks are managed accordingly. For example, the need to prevent deep vein thrombosis, decubitus ulcers, and ventilator-associated infections in patients on life support, neurological and circulatory injury in restrained patients, blood exposure in dialysis patients, central line infections and falls.

The organisation should ensure that there are procedures for ensuring records are stored, kept confidential, secure, retained and or destroyed in accordance with law and legislation.

New Requirement ARP.2.1.11: Patients with long term conditions e.g. chronic kidney disease, hypertension, depression, diabetes, HIV are assessed for risk to protect patients from unintended consequences of care or treatment and identified risks are managed accordingly.

## Medication Management (MM)

### Overview

The purpose of Medication Management is to provide a framework for safe and effective Medication Management system.

Medication Management is an important component of all aspects of patient's care including preventive, palliative, symptomatic or curative care. The most common treatment used in healthcare is medicines, and there is a high incidence of errors and adverse events with its use. These adverse events may be harmful and costly but are potentially avoidable.

To prevent or eliminate any potential harm, the organisation should have a system that promotes safe and effective medication management.

Safe and effective Medication Management includes the following processes; procurement, storage, prescribing, transcribing, preparing and dispensing.

All processes of Medication Management of the organisation comply with rules and regulations of the Pharmacy Council of Nigeria.

Medication errors can occur in any of the stages of medication management; but standardisation and systemisation of processes identifies areas that are error prone and help to prevent or eliminate the errors bearing in mind the complexity of the process.

Medication safety also involves timely reporting of near misses or adverse events which would help to highlight areas of improvement.

A qualified individual oversees the medication management process.

**MM.4.1.: Process of medication management and procurement**

**Intent**

The organisation has a process of stocking medicines that are frequently used in the organisation and those for special requests in the care of patients. The procurement process for medicines complies with the applicable local, state or national guidelines. The organisation determines the list of medicines (formulary) to be made available for use in the care of patients. When there is need for a drug outside of the formulary in the care of a patient, the organisation should have a policy that guides the process of approval and procurement. The procurement process of the hospital shall identify at a minimum; stock level, where to buy, how to buy and storage. Occasionally, medicines that are not stored by the health facility may be required, the procurement process of the hospital should identify how such medicines are approved and procured.

The list of medicines to be made available in the organisation is guided by the following criteria:

a) Indications for use

b) Effectiveness

c) Drug interactions

d) Potential for errors and abuse

e) Adverse drug events

f) Other risks

g) Cost

The review of the list of medicines that are available in the hospital is done yearly and guided by a policy.

The organisation appoints a committee and/or an individual to have oversight of the medication management process.

MM.4.1.4.: The medication management complies with the laws and legislations of Pharmacy Council of Nigeria, The National Agency for Food and Drug Administration and control.

MM.4.1.7.: The organisation has a multidisciplinary committee that has an oversight function of maintaining the list and use of medicines.

**MM.4.2**.: **Storage of Medicines**

**Intent**

The organisation identifies areas where medicines can be stored. This may include pharmacy, cold storage, wards etc. Appropriate medication storage helps to maintain integrity of medicines, ensure availability when needed and reduce potential dispensing errors. Appropriate medication storage would include:

Ensuring that medications are stored according to manufacturer's instructions so as to ensure stability and potency before use.

There is a process for storage of concentrated electrolytes to prevent inadvertent administration.

All reagents or medicines used in the preparation of other medicines are properly labelled.

There are adequate and up to date records detailing the use of controlled substances. This is according to the regulations of the National Agency for Food and Drug Administration and Control (NAFDAC) and the Pharmacy Council of Nigeria (PCN).

Areas where medicines are kept are frequently inspected to ensure they are stored properly and safely.

The organisation has a process of storing emergency medicines for easy access in case of emergencies.

MM.4.2.1.: The organisation ensures that medicines are stored according to manufacturer's recommendation, The National Agency for Food and Drug Administration and control, Pharmacy Council of Nigeria (PCN).

MM.4.2.9.: The organisation has a documented process for disposing of expired or contaminated medicines.

MM.4.2.10.: Medicines are kept in refrigerators reserved solely for medication storage.

MM.4.5.4. Medication errors are regularly monitored, reported, and investigated. Reporting of errors are non-punitive to encourage reporting, proper root cause analysis and hence prevent or reduce recurrences.

## Patient Safety (PS)

### Overview

The aim of this chapter is to keep patients from harm and to improve the quality of healthcare through the patient safety standards. Patient safety standards are evidence-based areas of healthcare, the absence of which have been found to cause harm to patients.

The standards ensure that mechanisms are put in place to promote safety and quality in healthcare.

**PS.5.1.: Preventing Healthcare Associated Infections**

**Intent**

The Management of the organisation implements systems to prevent and manage healthcare associated infections. The adopted systems are communicated to all staff to achieve appropriate outcomes.

All healthcare workers directly or indirectly prevent transmission of infections through hand hygiene, because the hands are the main source of transmission of infectious agents. Hand hygiene is therefore the most important method of preventing transmission of infection from health care provider to patients, from patients to healthcare provider or from one patient to another patient.

Healthcare Associated infections are a global issue which occurs both in developing and developed countries. The system involves processes to prevent patients from acquiring healthcare associated infections through evidence-based hand hygiene practices.

PS.5.1.5.: The organisation has guidelines for post exposure prophylaxis after needle stick injuries, body fluids or secretions

**PATIENTS' RIGHTS AND EDUCATION (PRE)**

**Overview**

Patients are at the centre of everything the organisation does, through patients' right and education. The organisation does this by advocating for the needs of patients, protecting their rights, respecting their values, beliefs, preferences and diversity and actively involving them in the provision of care.

Better patient satisfaction or outcome is achieved when patients are adequately informed about their care, their rights are respected and they are involved in the decision making process.

Patients' rights and education promotes kindness, consideration and respect for patients' dignity, privacy and autonomy.

The organisation must also ensure that patients are assessed for nutritional needs and they are educated on their nutritional needs based on assessment.

**PRE.6.3.: Patients' Education**

PRE.6.3.2. There is a documented process to educate patients about their medicines, nutrition, use of medical equipment and wellbeing.

PRE.6.5.1. The organisation must state clearly if they are involved in research, teaching and development and must obtain consent from the intended patients

## Laboratory (LAB)

**Overview**

## Laboratory services are an essential component of quality healthcare service delivery.

The purpose of these standards is to provide guidance on development and implementation of quality systems for laboratory services to ensure accuracy of test results, increase patients' confidence and healthcare professionals in the value of laboratory testing and to inform patient management.

These standards would help health organisations meet regulatory requirements either at local, state or national levels, thereby ensuring laboratory safety and consistency of performance. It is important that quality laboratory results are achieved to support clinical diagnosis, rationalize and monitor treatment. Prompt and quality results can also be useful in epidemiological purposes, surveillance and control of disease of public health importance and provide early warning of disease outbreaks

**LAB.7.1. Laboratory Services are available. (New Standard)**

**Intent:**

The organisation has a structure for providing laboratory services for categories of patients seen to enable healthcare givers make an informed decision about patients' care. The laboratory services provided by the organisation must be carried out in a manner that it meets the legal and regulatory requirements of Medical Laboratory Science Council of Nigeria and/or the local, State or National laws.

Outside laboratory sources should be identified based on the recommendation of the individual who heads the laboratory services. Outside laboratories must meet the required State and National laws and regulations.

LAB.7.1.1. The organisation has defined and documented the laboratory services available in the organisation.

LAB.7.1.2.: The laboratory services comply with state and federal laws and regulations.

LAB.7.1.3.: Laboratory services are available to meet the needs related to the patient population and enable the hospital meets its mission outside opening hours.

LAB.7.1.4.: Referral laboratories are selected based on an acceptable record and compliance with laws, regulations and recognized professional standards.

**LAB.7.2.: Management and Responsibilities (New Standard)**

**Intent:**

Clinical laboratory staff have clearly defined roles and responsibilities and the required education, qualifications, and experience to administer and perform the tests and interpret the results. Intent Leadership of clinical laboratory services are under assigned to an individual who has the appropriate documented qualifications, training, expertise, and experience, consistent with applicable laws and regulations. S/he has responsibility for the laboratory facility and the services provided in the laboratory as well as tests performed outside the laboratory, such as those performed at the point of care or by contracted laboratories. Responsibilities of the laboratory leader include: i. ii. iii. iv. developing, implementing, and maintaining policies and procedures administering, monitoring, and reviewing all laboratory services. a quality control and safety program recommending outside sources of laboratory services and monitoring their performance The hospital identifies the education, training, qualifications, and experience of laboratory staff members performing and interpreting laboratory tests, those who are approved to perform point-of-care screening tests at the bedside, and those who direct or supervise staff who perform testing.

LAB 7.2.1. The clinical laboratory, and other laboratory services throughout the hospital, are under the direction and oversight of one or more qualified individuals with defined roles and responsibilities.

LAB 7.2.2. All laboratory staff have the training, educational qualifications and license necessary to administer, perform, and interpret tests.

LAB 7.2.3. Supervisory staff are identified and have the proper qualifications and experience.

LAB 7.2.4. Experts in specialized diagnostic areas are contacted when needed.

LAB 7.2.5. A staffing plan to ensure tests are performed promptly and provide staffing coverage during all hours of operation, emergencies inclusive, is implemented.

**LAB.7.3. Point-of-Care Testing**

**Intent**

Point-of-care testing (POCT) is testing performed at sites outside the regular laboratory environment, usually at or near where care is delivered to the patient. Oversight and supervision for testing performed in all areas are provided by the individual responsible for managing the laboratory services or a designee. The hospital must have a clearly defined and well-structured approach to POCT to ensure that it is performed safely and correctly and that the results generated are accurate and reliable. A POCT program includes planning for tests to be performed and identifying the areas of the hospital where they will be performed, identification of staff who will be performing the test(s), and a protocol for reporting abnormal test results, including critical results. All staff performing POCT require training for each test being performed, along with a competency evaluation to ensure that results are accurate. Quality control (QC) should be performed for each test as recommended by the manufacturers e.g., daily or weekly checks, as well as between new batches of test kits. QC testing documentation, and evaluation should be performed within defined specifications recommended by the manufacturer.

A POCT program should be monitored and evaluated to ensure that it is meeting its' objectives by developing and monitoring quality improvement measures, reviews of utilization reports and reviews of quality control and proficiency testing results.

LAB 7.3.1. The individual responsible for managing the laboratory services, or a designee, also has oversight and supervisory responsibilities for the POCT program.

LAB 7.3.2. There are policies and procedures guiding POCT.

LAB 7.3.3. Reference intervals for POCT results are available and readily accessible to staff performing POCT testing.

LAB 7.3.4. The POCT program includes a defined process for reporting abnormal test results, including reporting critical results.

LAB 7.3.5. POCT results are documented in the patient's medical record and include the following at minimum: date and time of test, test results, name of person who performed the test, the requesting physician (as appropriate), action taken to notify the most responsible physician about the results, and date and time of result notification.

LAB 7.3.6. Infection prevention and control measures are established and implemented to ensure safe use of devices.

LAB 7.3.7. The POCT program includes quality control performance, documentation, and evaluation.

LAB 7.3.8. The POCT program is monitored, evaluated, and included in quality improvement activities.

LAB 7.3.9. All healthcare professionals performing POCT must have the required qualifications, must be trained, and successfully demonstrate competency for each device.

LAB 7.3.10. Competency assessments should be done annually for all healthcare professionals for every Point of Care (POC) device or test they use.

**LAB.7.4.: Facilities**

**Intent**

Laboratory facilities are adequate to provide a safe and effective laboratory service. Service managers need to work closely with facility managers to ensure that facilities are available for the provision of the required services. Service managers must keep facility managers informed about inadequate facilities and the current state of facilities. The laboratory should have sufficient space and appropriate work surfaces, power, water and ventilation preferably temperature controlled. Appropriate washing and staining facilities should be provided. Separate handwashing facilities are required.

LAB 7.4.1. The laboratory is a designated area with limited access to non-authorized personnel.

LAB 7.4.2. The size of the laboratory is appropriate for the services provided.

LAB 7.4.3. The walls, ceilings and floors are easy to clean, impermeable to liquids and resistant to chemicals.

LAB 7.4.4. There is sufficient and appropriate work surfaces to perform activities.

LAB 7.4.5. Each laboratory compartment is adequately ventilated, and the room temperature is recorded and maintained.

LAB 7.4.6. Handwashing facilities with running water, soap and paper towels are provided in each laboratory room.

LAB 7.4.7. Separate facilities are provided for personnel to store personal items.

LAB 7.4.8. Separate rest area where personnel can eat, and drink are provided.

**LAB.7.5.: Laboratory Equipment**

**Intent**

It is essential that the required equipment is available to provide effective laboratory services. Laboratory staff work to ensure that all equipment function at acceptable levels and in a manner that is safe to the operator(s). The laboratory develops and implements a program to provide and manage equipment including medical devices used for point-of-care testing. The laboratory equipment management program is documented and includes:

laboratory equipment and medical equipment selection and acquisition

identification and taking inventory of laboratory equipment and medical equipment

assessment of laboratory equipment use through inspection, testing, calibration, and maintenance according to manufacturers' instructions

monitoring and acting on laboratory equipment hazard notices, recalls, reportable incidents, problems, and failure.

In addition, only licensed laboratory staff who have received equipment-specific instruction from qualified trainers and shown competence through supervised practice shall be

authorised to operate any laboratory or point-of-care device. The laboratory shall maintain up-to-date training records for each operator, including dates of initial instruction and any subsequent refresher sessions.

LAB 7.5.1. The laboratory develops and implements, a documented equipment management program to manage laboratory equipment, including i) to iv) in the intent.

LAB 7.5.2. There is a documented inventory of all laboratory equipment.

LAB 7.5.3. Laboratory equipment is inspected and tested on acquisition and according to the manufacturers' recommendations and the inspections are documented.

LAB 7.5.4. The laboratory develops and implements a calibration and planned preventive maintenance schedule according to manufacturers' recommendations, and the calibration and maintenance are documented.

LAB 7.5.5. The hospital has a system in place for monitoring and acting on laboratory equipment hazard notices, recalls, reportable incidents, problems, and failures.

Laboratory instruments and point-of-care devices shall be operated only by laboratory staff who have received equipment-specific training and demonstrated competence through supervised practice.

The laboratory shall keep up-to-date training records for every equipment operator, including dates of initial instruction and any refresher sessions provided when new instruments or procedures are introduced

**LAB 7.6.: Reagents, Test Kits, and Supplies**

**Intent**

The hospital has identified those essential reagents, test kits, and supplies required to provide laboratory services to its patients and ensures they are available. There is a process to order or secure those essential reagents and supplies. Processes address situations when equipment malfunction or when reagents are not available.

All reagents are stored and dispensed according to manufacturers' directives. All equipment and reagents are labelled, stored, and evaluated according to written guidelines to ensure accuracy and precision of results.

LAB 7.6.1. Essential reagents, test kits and supplies are identified and available, and there is a process to address when essential reagents are not available.

LAB 7.6.2. All reagents test kits and supplies are stored and dispensed according to manufacturers' instructions.

LAB 7.6.3. The laboratory establishes and follows written guidelines for the evaluation of all reagents and test kits to ensure accuracy and precision of results.

LAB 7.6.4. All reagents, test kits and solutions are completely and accurately labeled.

**LAB 7.7.: Handling of Specimen**

**Intent**

The quality of the specimen at the time of testing directly impacts the results of the tests. It is therefore necessary to ensure specimen are collected, transported, and stored in the correct manner. Documented procedures for collecting, identifying, handling, safely transporting, and disposing of specimens should be established and implemented.

Processes for correct identification of specimen should be established and followed to avoid mix-up of specimen leading to wrong results being given to the wrong patient.

LAB 7.7.1. Procedures are established and implemented for the ordering of tests.

LAB 7.7.2. Test request forms and specimen labels include unique patient identifiers and adequate supporting information according to established procedures.

LAB 7.7.3. Specimens are collected and identified according to established procedures.

LAB 7.7.4. Specimens are transported, stored and preserved according to established procedures.

LAB 7.7.5. Specimens are received and tracked according to established procedures.

LAB 7.7.6. Specimen are disposed of according to established procedures.

LAB 7.7.7. Procedures are established and followed for requesting tests and handling of specimen for outside laboratories.

**LAB. 7.8.: Clinical laboratory Results and Reporting.**

**Intent**

The laboratory must establish reference intervals or "normal" ranges for each test performed. The range is included in the medical record, either as part of the report or by including a current listing of such values approved by the laboratory leader. Ranges are provided when a reference/contract laboratory service performs the test. The reference ranges should be appropriate to the hospital's community and should be reviewed and updated when methods change.

LAB 7.8.1. The laboratory has established reference ranges for each test performed including population specific values.

LAB 7.8.2. Results are reported according to established procedures.

LAB 7.8.3. The range is included in the test results which are included in the patient's medical record.

LAB 7.8.4. Ranges are provided when tests are performed by reference/contract laboratory services.

LAB 7.8.5. Norms and ranges are reviewed and updated as needed.

**LAB 7.9.: Time Frames for Reporting Test Results**

**Intent**

The hospital establishes time frames for reporting laboratory test results including for emergencies, after regular hours and weekends. Results from urgent tests, such as those from the emergency department, operating theatres, and intensive care units, are given special attention in the laboratory and hospital's quality management program.

Time frames for services provided by outside laboratories are stipulated in hospital policy or in the contract with the organisation. These are also monitored as part of the quality management program.

LAB 7.9.1. The hospital establishes the expected turn-around time for test results.

LAB 7.9.2. Laboratory results are reported within a time frame to meet patient needs.

LAB 7.9.3. The hospital measures the timeliness of reporting of urgent/emergency tests.

LAB 7.9.4. The hospital acts on the findings of these measurements

**LAB.7.10. Laboratory Safety**

**Intent**

Laboratory is a potentially dangerous place to work in due to chemical, electrical, physical, mechanical or biological hazards. Those at risk include laboratory staff, patients and visitors entering the laboratory; it is therefore important that laboratory staff can recognise and minimise the potential dangers. The level of risk is dependent on the activities that are carried out in the laboratory.

The laboratory or any area in the organisation where tests are carried out must be safe for the staff, patients and visitors. The organisation must promote safety awareness and encourage safe working practices in the laboratory through the development of a safety programme.

LAB.7.10.1. The Laboratory has a safety programme that has been incorporated into the safety programme of the organisation.

LAB.7.10.2. The safety program addresses potential safety risks in the laboratory and other areas outside the laboratory where laboratory services are provided.

LAB.7.10.3. There is a documented process that the staff of the laboratory have been trained on the safe handling, use and maintenance of laboratory equipment.

LAB.7.10.4. An individual has been identified to be the laboratory safety officer and shall be responsible for monitoring compliance to the safety programme.

LAB 7.10.5. The laboratory safety program is part of the hospital's infection prevention and control program and reports to the infection prevention and control program regularly as determined by the hospital and when any infection control events occur.

LAB 7.10.6. Identified safety risks are addressed by specific processes and/or devices to reduce the safety risks.

LAB 7.10.7. Laboratory staff are oriented to safety procedures and practices and receive ongoing education and training for new practices and procedures.

LAB 7.10.8. Infections acquired in the laboratory are reported, as defined in the policy, and in compliance with applicable laws and regulations.

LAB 7.10.9. When problems with practice are identified, or accidents occur, corrective actions are taken, documented, and reviewed.

**LAB 7.11. Quality Control and Quality Assurance**

**Intent**

Well-designed internal and external quality control and quality assurance systems are essential to providing excellent pathology and clinical laboratory services.

Quality control procedures include:

validation of the test methods used for accuracy, precision, and reportable range,

daily surveillance of results by qualified laboratory staff,

testing of reagents,

rapid corrective action when a deficiency is identified; and

documentation of results and corrective actions.

The laboratory participates in an approved proficiency-testing program with a recognized organisation or by conducts proficiency testing by exchanging samples with a laboratory in another organisation for purposes of peer comparison testing. The laboratory maintains a cumulative record of participation in a proficiency-testing process.

LAB 7.11.1. The hospital establishes and implements a quality control program for the clinical laboratory.

LAB 7.11.2. The program includes the validation of test methods. LAB

7.11.3. The program includes daily surveillance and documentation of test results.

LAB 7.11.4. The program includes testing of reagents.

LAB 7.11.5. The program includes rapid correction and documentation of deficiencies.

LAB 7.11.6. The laboratory participates in a proficiency-testing program, or a peer comparison testing program.

LAB 7.11.7. The laboratory's proficiency testing results meet satisfactory performance criteria for each specialty, subspecialty, analyte, or test, in accordance with laws and regulations.

LAB 7.11.8. The laboratory maintains records of its participation in a proficiency-testing program.

LAB 7.11.9. The facility regularly reviews quality control and proficiency testing results from all outside sources of laboratory services.

**LAB 7.12. Blood Banking and Transfusion Service**

**Intent**

The hospital develops and implements documented processes for the delivery of safe and efficient blood banking services to meet the needs of the healthcare professionals and the community served. This should include processes to provide blood in emergencies or when massive transfusion is required.

The processes include:

blood donor selection.

blood collection.

blood storage.

compatibility testing; and

blood distribution.

Quality control processes for all blood bank services are established, implemented, and documented to ensure the safety of blood bank and transfusion services.

LAB 7.12.1. The blood bank and transfusion services comply with applicable State laws and regulations and recognized standards of practice.

LAB 7.12.2. The blood bank has established, implemented documented processes for items (i) - (v) outlined in the intent.

LAB 7.12.3. Documented quality control measures are established, implemented, and recorded.

## Medical Imaging and Radiology (RAD)

### Overview

Multiple imaging modalities may be required due to the complex nature of disease processes with an interdisciplinary team including clinicians, radiographers and support staff all playing critical roles in the delivery of quality healthcare to patients.

Medical imaging and radiology services must be available to meet patients 'needs either within the organisation or outside facility. Depending on the scope of the medical imaging services offered by an organisation. It is expected that it meets certain requirements to deliver, quality and safe imaging services.

Radiography includes the integration of scientific knowledge, technical competence and interaction with patients to provide safe and accurate procedures with highest regard to all aspects of patient care.

### RAD.8.2.: Management and Responsibilities

Radiology and diagnostic imaging staff have clearly defined roles and responsibilities and the required education, qualifications, and experience to administer and perform the tests and interpret the results.

### Intent

Leadership of diagnostic imaging services are under assigned to an individual who has the appropriate documented qualifications, training, expertise, and experience, consistent with applicable laws and regulations. S/he has responsibility for the diagnostic imaging facility and the services provided in the hospital as well as tests performed outside the radiology and diagnostic imaging facility, such as those performed at the point of care or by contracted laboratories.

Responsibilities of the radiology and diagnostic imaging services leader include:

developing, implementing, and maintaining policies and procedures

administering, monitoring, and reviewing all diagnostic imaging services.

a quality control and safety program

recommending outside sources of imaging services and monitoring their performance

The hospital identifies the education, training, qualifications, and experience of diagnostic imaging staff members performing and interpreting imaging tests, those who are approved to perform point-of-care screening tests at the bedside, and those who direct or supervise staff who perform testing.

RAD.8.2.1 The radiology and diagnostic imaging services throughout the hospital, are under the direction and oversight of one or more qualified individuals with defined roles and responsibilities including i) to iv) in the intent.

RAD.8.2.2 All laboratory staff have the training, educational qualifications, and license necessary to administer, perform, and interpret tests.

RAD.8.2.3 Supervisory staff are identified and have the proper qualifications and experience.

RAD.8.2.4. Experts in specialized diagnostic areas are contacted when needed.

RAD.8.2.5 A staffing plan to ensure tests are performed promptly and provide staffing coverage during all hours of operation, emergencies inclusive, is implemented.

**RAD.8.3. Point-of-Care Testing**

**Intent**

Point-of-care testing (POCT) is testing performed at sites outside the regular diagnostic imaging environment, usually at or near where care is delivered to the patient.

Oversight and supervision for imaging studies performed in all areas are provided by the individual responsible for managing the diagnostic imaging services or a designee. The hospital must have a clearly defined and well-structured approach to diagnostic imaging.

POCT to ensure that it is performed safely and correctly and that the results generated are accurate and reliable.

A POCT program includes planning for tests to be performed and identifying the areas of the hospital where they will be performed, identification of staff who will be performing the test(s), and a protocol for reporting abnormal test results, including critical results. All staff performing POCT require training for each modality being performed, along with a competency evaluation to ensure that results are accurate.

Quality control (QC) should be performed for each modality as recommended by the manufacturers e.g. daily or weekly checks. QC testing documentation, and evaluation should be performed within defined specifications recommended by the manufacturer.

A POCT program should be monitored and evaluated to ensure that it is meeting its' objectives by developing and monitoring quality improvement measures, reviews of utilization reports and reviews of quality control and proficiency testing results.

RAD.8.3.1 The individual responsible for managing the diagnostic imaging services, or a designee, also has oversight and supervisory responsibilities for the POCT program.

RAD.8.3.2 There are policies and procedures guiding POCT.

RAD.8.3.3 The POCT program includes a defined process for reporting abnormal test results, including reporting critical results.

RAD.8.3.4 POCT results are documented in the patient's medical record and include the following at minimum: date and time of test, test results, name of person who performed the test, the requesting physician (as appropriate), action taken to notify the most responsible physician about the results, and date and time of result notification.

RAD.8.3.5 Infection prevention and control measures are established and implemented to ensure the safe use of devices.

RAD.8.3.6 The POCT program includes quality control performance, documentation, and evaluation.

RAD.8.3.7 The POCT program is monitored, evaluated, and included in quality improvement activities. RAD.8.3.8 All healthcare professionals performing POCT must have the required qualifications, must be trained and successfully demonstrate competency for each device.

**RAD.8.4.: Safety**

**Intent**

The organisation shall conduct all diagnostic imaging and radiology services in a manner which ensures the safety of patients, staff, visitors and the environment. The safety programme of the organisation must address potential risks or hazards that maybe encountered during service delivery.

As a minimum all applicable regulatory requirements to deliver safe medical imaging and radiology services must be met. The organisation must demonstrate through its policies, procedures and radiation safety protocols that it complies with the ALARA principles. The safety programme of the unit shall include:

Safety Manual that includes policies and procedures on prevention and corrective measures for safety issues

Record of compliance to laws and regulations of Nigerian Nuclear Regulatory authority and /or Local, State and Federal laws.

Orientation and re-training of the Staff on the safety policies and procedures

Management of Hazardous agents

Safe use and handling of equipment

Infection prevention and control practices

RAD.8.4.1. The Radiology and medical imaging safety programme is incorporated into the organisation's safety programme.

RAD.8.4.2. The programme includes i-vi of the intent.

RAD.8.4.3. There is a documented process that staff of the Radiology unit has been trained on the safe handling, use and maintenance of imaging equipment.

RAD.8.4.4. An individual has been identified to be the radiation safety officer and shall be responsible for monitoring compliance to the safety programme.

**RAD.8.5 : Facilities**

**Intent**

Radiology and diagnostic imaging facilities are adequate to provide a safe and effective imaging service. Service managers need to work closely with facility managers to ensure that facilities are available for the provision of the required services. Service managers must keep facility managers informed about inadequate facilities and the current state of facilities.

The diagnostic imaging should have sufficient space and appropriate work surfaces, power, water and ventilation. Separate handwashing facilities are required.

RAD 8.5.1. The diagnostic imaging is a designated area with limited access to non-authorized personnel.

RAD 8.5.2. The size of the diagnostic imaging rooms are appropriate to the services provided.

RAD 8.5.3. The walls, ceilings and floors are easy to clean, impermeable to liquids and resistant to chemicals.

RAD 8.5.4. Each diagnostic imaging compartment is adequately illuminated and ventilated, and the room temperature is recorded and maintained.

RAD 8.5.5. Handwashing facilities with running water, soap and paper towels are provided in each diagnostic imaging room as appropriate.

RAD 8.5.6. Separate facilities are provided for personnel to store personal items.

RAD 8.5.7. Separate rest area where personnel can eat, and drink is provided.

**RAD 8.6.: Diagnostic Imaging Equipment**

**Intent**

It is essential that the required equipment is available to provide effective diagnostic imaging services. Diagnostic imaging staff work to ensure that all equipment function at acceptable levels and in a manner that is safe to the operator(s).

Only trained and licensed radiology personnel who have demonstrated competence during supervised application of imaging protocols shall be permitted to use any diagnostic or point-of-care equipment.

The diagnostic imaging department develops and implements a program to provide and manage equipment including those used for point-of-care testing. The diagnostic imaging equipment management program is documented and includes:

v. diagnostic imaging equipment and medical equipment selection and acquisition

vi. identification and taking inventory of diagnostic imaging equipment and medical equipment

vii. assessment of diagnostic imaging equipment use through inspection, testing, calibration, and maintenance according to manufacturers' instructions

viii. monitoring and acting on diagnostic imaging equipment hazard notices, recalls, reportable incidents, problems, and failure.

RAD 8.6.1. Diagnostic imaging develops and implements a documented equipment management program which includes i) to iv) in the intent.

RAD 8.6.2. There is an updated documented inventory of all diagnostic imaging equipment.

RAD 8.6.3. Diagnostic imaging equipment is inspected and tested on acquisition and according to the manufacturers' recommendations and these inspections are documented.

RAD 8.6.4. Diagnostic imaging develops and implements a calibration and planned preventive maintenance schedule according to manufacturers' recommendations, and the calibration and maintenance are documented.

RAD 8.6.5. The hospital has a system in place for monitoring and acting on diagnostic imaging equipment hazard notices, recalls, reportable incidents, problems, and failures.

**RAD 8.7.: Essential Supplies**

**Intent**

The hospital has identified those essential supplies required to provide diagnostic imaging services to its patients and ensures they are available. There is a process to order or secure those supplies. Processes address situations when equipment malfunction or when supplies are not available.

All supplies are stored and dispensed according to manufacturers' directives. All equipment and reagents are labelled, stored, and evaluated according to written guidelines to ensure accuracy and precision of results.

RAD 8.7.1. Essential supplies are identified and available, and there is a process to address situations when they are not available.

RAD 8.7.2. All supplies are stored and dispensed according to the manufacturers' instructions.

RAD 8.7.3. All supplies are completely and accurately labeled as appropriate.

**RAD 8.8.: Expected Time Frames for Reporting Results**

**Intent**

The hospital establishes time frames for reporting diagnostic imaging results including for emergencies, after regular hours and weekends. Results from urgent studies, such as those from the emergency department, operating theatres, and intensive care units, are given special attention in the departmental and hospital-wide quality management program.

Time frames for services provided by outside diagnostic imaging services are stipulated in hospital policy or in the contract with the organisation. These are also monitored as part of the quality management program.

RAD 8.8.1. The hospital establishes the expected time frame for reporting imaging results.

RAD 8.8.2. Diagnostic imaging results are reported within a time frame appropriate to meet patient needs.

RAD 8.8.3. The hospital measures the timeliness of reporting urgent/emergency studies.

RAD 8.8.4. The hospital acts on the findings of these measurements

**RAD 8.9.: Quality Control (QC) and Quality Assurance**

**Intent**

Well-designed quality control and quality assurance systems are essential to providing excellent.

Quality control procedures include:

validation of the test methods used for accuracy, precision, and reportable range,


regular surveillance of results and documentation by qualified staff,

testing of reagents,

rapid corrective action when a deficiency is identified; and

documentation of results and corrective actions.

RAD 8.9.1. The hospital establishes and implements a quality control program for the diagnostic imaging services which include i) to v) in the intent.

RAD 8.9.2. The program includes the validation of test methods.

RAD 8.9.3. Quality control includes regular surveillance and documentation of imaging results.

RAD 8.9.4. The program includes testing of reagents when used.

RAD 8.9.5. The program includes documentation and rapid correction of deficiencies.

RAD 8.9.6. The facility regularly reviews quality control and proficiency testing results from all outside sources of diagnostic imaging services.

# ORGANISATION CENTRED STANDARDS

## HOSPITAL HYGIENE AND INFECTION PREVENTION AND CONTROL (IC)

### Overview

Because infectious agents continue to evolve overtime, they continue to present new challenges for infection prevention and control within healthcare organisations. Patients are at risk of developing healthcare associated infections because of decreased immunity among patients; the increasing variety of medical procedures and invasive techniques creating potential routes of infection; and the transmission of drug-resistant bacteria among crowded hospital populations, with poor infection control practices.

These conditions provide opportunities for the spread of infectious organisms. Healthcare associated infections are among the most common complications affecting patients in hospitals. Some of these infections require stronger and more expensive medicines (with the added risk of complications), and may result in long-term disabilities or even death.

In addition to significant patient harm caused by healthcare associated infections, such infections increase patient use of health services (such as extending length of stay and reducing access to available beds) and place greater demands on the clinical staff (such as laboratory tests and other tools to diagnose the infection).

The purpose of this chapter is to prevent the transmission or control transmission of infectious organisms between patients, healthcare providers, and visitors.

### IC.1.1. Comprehensive Infection prevention and control Programme

**Intent**

Hospitalised patients and staff are at risk of acquiring infection in the hospital because it is a place where the infected and people at risk of infection congregate. Hospital acquired infections are among the major causes of death and morbidity in hospitals. Hence, the need for an infection prevention and control programme that will identify and reduce the risk of transmission of infection between patients, care providers and visitors. It is imperative that the organisation identifies a group of people that will coordinate and have oversight function of the infection prevention and control programme. The organisation should have a coordinated programme to ensure the safe prescribing and use of antibiotics through antimicrobial stewardship programme and members of staff and patients are educated appropriately.

The infection prevention and control programme will include hand washing, cleaning requirements, and

structures and resources

use of isolation and precaution techniques

use of antibiotics (according to a local formulary)

sterilisation and decontamination activities

collection, analysis and use of infection event data

reporting of results of the programme.

on-going staff education

proper disposal of waste

availability of potable water.

Reportable diseases as required by laws and regulations.

Assessment and management of patients at risk of infection

The hospital has a comprehensive infection prevention and control programme which is in accordance with health and safety laws of the local, state and Federal Republic of Nigeria

IC. 1.1.1.: A person or persons must be designated as infection prevention and control officer(s)

IC. 1.1.2. There is an infection prevention and control or hygiene programme that covers clinical and non-clinical areas.

IC.1.1.3. The organisation has an infection prevention and control committee that coordinates the infection prevention and control practices, and an individual has been identified to oversee such activities.

IC.1.1.4. The infection prevention and control programme includes proper waste disposal, including medical and non-medical waste.

IC.1.1.5. The infection prevention and control programme includes i-xi of the intent and hand hygiene practices.

IC.1.1.6. The infection prevention and control programme includes infection prevention and control policies and procedures for clinical and non-clinical areas of the hospital.

IC.1.1.11. There is evidence that the Infection Prevention and Control Team conducts rounds with monitoring activities to ensure staff compliance with hospital policy.

IC.1.1.12. There is evidence that results of infection prevention and control monitoring activities are acted upon.

**IC.1.2.: Surveillance of Healthcare Associated Infections (HAIs)**

**Intent:**

Effective surveillance of healthcare-associated infections (HAIs) is vital for identifying infection risks, detecting trends, and implementing targeted interventions to prevent infection transmission within healthcare settings. A robust surveillance system allows healthcare facilities to monitor the incidence and prevalence of HAIs, track the effectiveness of infection control practices, and take corrective actions to minimize infection risks.

The aim is to systematically track, analyze, and respond to HAIs through evidence-based surveillance practices. This ensures the reduction of infection rates to the lowest possible levels and promotes a safer environment for both patients and healthcare workers.

Surveillance results also inform continuous improvements in infection prevention protocols and compliance with regulatory standards.

IC.1.2.1. The organisation has a policy for regular surveillance of healthcare associated infections, following national guidelines and evidence-based practices.

IC.1.2.2. The organisation tracks infection risks, rates, and trends through systematic data collection and analysis

IC.1.2.3. Surveillance findings are communicated regularly to healthcare personnel and management, to inform decision-making and improve infection control practices

IC.1.2.4. The organisation uses surveillance data to design and update processes to prevent specific HAIs, such as catheter-associated urinary tract infections (CAUTIs), ventilator-associated pneumonia (VAP), central line-associated bloodstream infections (CLABSIs), surgical site infections (SSIs), multidrug resistant organisms (MDROs) and epidemiologically significant infections.

IC.1.2.5. The organisation has a policy for regularly comparing its infection rates with national or international databases to assess performance and identify areas for improvement.

## GOVERNANCE AND LEADERSHIP (GL)

### Overview

A successful healthcare organisation requires effective leadership. This chapter addresses how leaders create integrated governance systems that maintain and improve the reliability and quality of patient care, as well as improve patient outcomes.

Various factors determine the quality and safety of healthcare provided by a hospital, some of these factors are:

A culture that promotes safety and quality

Provision of services that meet the needs of patient

Availability of resources –human, financial, physical and information

Staffing plan that includes adequate number and qualified staff

Monitoring and Evaluation of improvement activities.

These factors can only be provided by the leaders because only they have the resources, power, and control to make them available.

Quality Improvement activities of the organisation are dependent on the Mission, Vision and goals set by the leader.

**GL.2.5: Governance and Ethics**

**Intent**

The organisation ensures that all its decisions and actions conform to moral and professional principles of conduct. The ethical framework of the organisation supports ethical decision making in clinical care and non-clinical services and this includes marketing, admissions, transfer, discharge, and disclosure of ownership and any business and professional conflicts that may not be in patients' or organisation's' best interests. The framework should also support professional staff and patients when confronted with ethical issues during patient care.

GL.2.5.2. The governing body has established an ethical framework with defined timeframes.

GL.2.5.8. Ethical dilemmas are received and resolved within a defined timeframe.

**FACILITIES MANAGEMENT (FM)**

**Overview**

The resources used in the care of patients include human, physical, financial and natural resources. Safe, high-quality care, and support is intrinsically linked to how resources are used including how they are planned, managed, and delivered. Resources are finite


therefore, the effective, responsible stewardship of resources, including decisions on how they are allocated, is a fundamental factor in delivering high quality, safe and reliable care and support.

The organisation must maintain the quality of the care it provides while striving for greater efficiency or managing fewer resources. To achieve the goal of providing safe, functional, and supportive services, the management puts in place measures that:

a. Reduce and control hazards and risks

b. Prevent accidents and injuries

c. Maintain safe working conditions

The management provides:

Space, equipment, and resources that are required to deliver safe and effective care.

Members of staff with knowledge on how to reduce risks, monitoring and reporting of incidents and awareness of the environment in which they work.

Continuous evaluation of the system to identify areas of improvement.

The organisation has plans in place that addresses Fire Safety, Hazardous materials Management, Utility Management, Emergencies Management, and Safety & Security Management. The management of the facilities is in accordance with applicable laws of the Federal Republic of Nigeria

The needs of the various departments determine allocation of resources

**FM3.7: Facilities and Equipment at each level of care are appropriate to optimise health outcomes for all patients.**

**Intent:**
The resources used in the care of patients include human, physical, financial and natural resources. Safe, high-quality care and support is intrinsically linked to how resources are used. The resources used by an organisation to promote the delivery of quality and safe care include maintenance of medical equipment required in the care of patients which includes, testing, inventory, inspection, preventive maintenance and documentation of findings and remedial actions
Only personnel who have completed equipmentspecific training and demonstrated competence through formal assessments shall be authorised to operate, inspect, or maintain any medical or diagnostic equipment; records of these trainings and competency assessments must be kept and reviewed periodically.

Requirement:

The organisation shall ensure that only personnel who have completed equipment- and utility-system-specific training and demonstrated competence under direct supervision are permitted to operate inspect, test or maintain any specialised medical equipment and facility utility systems.

**FM.3.8.: Management of Medical Gases**

**Intent:**

Medical gases, such as oxygen, are critical in supporting patient care, especially in emergency, surgical, and intensive care environments. Effective management of these gases ensures their continuous availability, safe delivery, and proper usage, directly impacting patient outcomes and safety.

This standard aims to ensure that healthcare facilities have a structured system for managing both piped and mobile gas supplies. It emphasizes the need for regular equipment maintenance, proper storage, and immediate access to medical gases during emergencies. Additionally, it highlights the importance of having functional resuscitation equipment and ensuring that all gas-related systems are compliant with safety protocols.

A well-implemented system of medical gas management reduces risks, improves operational efficiency, and ensures that healthcare providers can focus on delivering timely and effective care without disruptions.

FM.3.8.1. The organisation ensures that all critical care areas have adequate supplies of oxygen and other medical gases at all times.

FM.3.8.2. Mobile oxygen cylinders and vacuum pumps are readily available and fully functional in areas where there is no piped oxygen or vacuum supply.

FM.3.8.3. There is a scheduled maintenance program to check all oxygen fittings, valves, and suction systems for functionality and safety.

FM.3.8.4. The organization maintains an adequate backup supply of oxygen, including portable cylinders, which are regularly monitored to ensure availability during emergencies or equipment failure.

FM.3.8.5. Oxygen cylinders are stored securely in all locations to prevent accidents.

**HUMAN RESOURCES MANAGEMENT (HR)**

**Overview**

Human Resources include all the people that work in, for or with the hospital and they are integral to ensuring the delivery of quality, patient-centred and safe care.

The organisation must be able to assure the public or patients that it can meet their needs and deliver quality and safe care through a team of dedicated and qualified staff.

The organisation determines the requirements for its staff when it sets the goals for delivery of quality and safe care. The staff must be skilled and competent and as a whole, the workforce is planned, configured and managed to achieve these goals.

Human Resources have a major role in the delivery of quality and safe care and must be supported by the Management. The support includes the Management providing safe physical environment for staff to work in, which is free from harassment or accidents.

To ensure that members of staff have the necessary competencies required for delivery of quality and safe care, there is an effective recruitment and planning of staff

**HR.4.5: The Delivery of Health Care is Supported by Qualified Personnel**

**Intent:**

The healthcare personnel engaged to provide the designated services at the organisation should be appropriately credentialed within the defined competencies and professional standards of practice as indicated by their specific professional bodies. This includes all employed, contracted and volunteer clinical personnel (including independent practitioners), each of whom must undergo formal appointment and privileging processes with documented verification of qualifications, licensure and professional body endorsements kept in personnel files. Competency assessments—such as structured orientation, direct-observation audits and refresher trainings—shall occur at least annually. Staff working in the hospital should have access to relevant, appropriate continuing education programmes to maintain their professional standards of practice and ensure currency in their special area of practice

Requirements:

The organisation shall implement a documented Credentialing & Privileging process for all independent practitioners and volunteers, including verification of education, licensure, background checks and scope-of-practice approval, with records maintained in HR files.

The organisation shall deploy a structured Orientation & Induction program for all new independent practitioners and volunteers, covering core SQHN standards (including patient safety, infection control, and confidentiality) with documented attendance. All independent practitioners and volunteers must submit annual proof of valid credentials, licensure and completion of required training. The organisation shall also provide—and require participation in—periodic refresher training sessions to ensure their continued competence.

The organisation shall maintain a Volunteer and Independent Practitioner Policy—reviewed at least every two years—that defines the roles, education requirements, supervision arrangements and credentialing processes (and performance-management) for volunteers and independent practitioners

**QUALITY IMPROVEMENT/RISK MANAGEMENT (QI)**

**Overview**

Quality Improvement recognises that the safety of the patient is paramount. An organisation that is focused on quality improvement continually looks for ways to promote patient safety and quality of care.

In a safe hospital, a focus on quality and safety improvement becomes part of a Hospital-wide culture and is embedded in the hospital's daily practices and processes rather than being viewed or undertaken as a separate activity.

Quality and safety improvements in healthcare include a patient-safety improvement programme that requires healthcare providers to proactively identify risk and to plan, implement and evaluate necessary changes to improve the quality and safety of services.

The organisation ensures regular evaluation of the patient-safety improvement programme through performance indicators and benchmarks to identify both positive outcomes and areas for improvement. Any necessary actions to improve the quality and safety of the services are implemented and learning is disseminated both internally and externally.

The Quality Improvement process includes the following 5 steps:

Identify areas for improvement

Determine what processes are required or need modification to improve outcomes.

Develop and execute strategies to improve quality

Track performance and the effect of the changes made.

Management and staff are informed of the results.

The Management of the organisation has the oversight function of ensuring a good quality improvement plan.

**QI 5.1: The Management plans and leads the quality improvement programme.**

**Intent:**

The leaders of the organisation are accountable for service performance. Therefore, for an effective quality improvement programme, the leaders lead and plan the quality improvement and patient safety programme. The Leaders and Management are involved in quality by identifying areas that require improvement, promoting learning from results of data, fostering a culture of quality & safe care, and allocating resources for improvement. They shall ensure a comprehensive Quality Improvement Plan is developed that addresses every clinical and support department with specific objectives and performance metrics. This Plan must be reviewed and updated at least annually and formally signed off by management before implementation. Depending on the complexity of services rendered by the organisation, Management may appoint an individual to oversee the quality improvement programme of the hospital.

Requirement:

The organisation shall maintain a standing multi-disciplinary Quality (Improvement) Committee with Terms of Reference mandating regular meetings at agreed intervals.

All departments in the organisation shall develop comprehensive Quality Improvement Plans that include clearly defined objectives, specific improvement activities, and measurable indicators tailored to each department's functions. The plan must be reviewed and updated at least once every 12 months to reflect progress, changing priorities, performance data and emerging risks. Each updated plan shall be approved and signed off by management.

QI.5.4. Data Collection and Analysis

QI.5.4.7. Reports on performance data and quality improvement activities are submitted as often as required to governing bodies.

**MEDICAL RECORDS (MR)**

**Overview**

Medical record is a collation of facts about a patient's life and health. It includes documented information on past and present illnesses and treatment carried out and written by healthcare professionals involved in the care of a particular patient.

The medical record "must contain sufficient data to identify the patient, support the diagnosis or reason for attendance at the health care facility, justify the treatment and accurately document the results of that treatment" (Huffman, 1990)

The objectives of the medical record include:

Recording facts about a patient's health with emphasis on events affecting the patient during the current admission or attendance at the health care facility, and

Continuity of care of the patient when health care is required in the future.

A patient's medical record should provide accurate information on:

who the patient is and who provided health care;

what, when, why and how services were provided; and

the outcome of care and treatment.

There are four major sections of the medical records and they include:

Administrative; which includes demographic and socioeconomic data such as the name of the patient (identification), sex, date of birth, place of birth, patient's permanent address, and medical record number;

Legal data including a signed consent for treatment by appointed healthcare provider and authorization for the release of information, next of kin

Financial data relating to the payment of fees for medical services and hospital accommodation

Clinical data and diagnostic results on the patient whether admitted to the hospital or treated as an outpatient or emergency patient

It is important to note that accurate, timely and accessible health care data plays a vital role in the planning, development and maintenance of health care services. The quality of information in the medical record and its availability is essential if health care professionals are to maintain health care at optimal level.

The main uses of the medical record are:

to document the course of the patient's illness and treatment;

to communicate between attending doctors and other health care professionals providing care to the patient

for the continuing care of the patient;

for research of specific diseases and treatment; and

the collection of health statistics.

**MR.6.5. Management of Electronic Medical Records (EMR)**

**Intent:**

The use of electronic medical records (EMR) plays a critical role in modern healthcare delivery, streamlining access to patient information, improving care coordination, and supporting clinical decision-making. However, with the digitalization of patient records comes the heightened responsibility of ensuring data security and patient privacy.

This standard focuses on protecting the confidentiality, integrity, and availability of patient information across all stages of its lifecycle, from collection and storage to transmission and destruction.

The intent is to safeguard sensitive patient data against unauthorized access, breaches, and potential misuse while ensuring that healthcare professionals have secure and timely access to the data they need to deliver safe and effective care. The organisation must adopt comprehensive policies to regulate who can access patient data, how data is stored and transmitted, and how breaches are handled.

In addition, ensuring the proper use of technology, such as encryption, firewalls, two-factor authentication, and audit trails, minimizes the risk of cybersecurity threats. The organisation must also plan for unexpected emergencies, ensuring that disaster recovery protocols are in place to maintain the availability and integrity of medical records in the event of system failures or security breaches. Regular education of staff on cybersecurity practices and the appropriate handling of EMR data is crucial to maintaining a secure environment for patient information.

This approach not only complies with regulatory standards but also builds trust with patients by demonstrating that their data is being handled with the utmost care and responsibility.

MR.6.5.1. The organisation has and implements a policy that protects the confidentiality, integrity, and security of electronic medical records, including encrypted data storage and transmission.

MR.6.5.2. Access to patient information is granted on a need-to-know basis, with a detailed register of access rights that tracks user roles, levels of access, and rescinded rights when staff leave the organization

MR.6.5.3. All staff accessing EMR systems must use two-factor authentication and the digital system must support single sign-on capabilities to enhance security.


MR.6.5.4. The design of the EMR system automatically terminates inactive sessions after a predetermined period and captures audit trails for all user activities in the system(D).

MR.6.5.5. A disaster recovery plan is in place to ensure the continuity of patient care and the security of medical records during emergencies or system failures. This includes provisions for data backup and recovery.

MR.6.5.6 Staff are trained in the strategies and tactics used for planned and unplanned downtime of data systems

# MATERNAL AND CHILD HEALTH STANDARDS

## MATERNAL AND CHILD HEALTH (MCH)

### Overview

Reductions in maternal and neonatal mortality are still slow despite some improvement that has been made in the last two decades in birth coverage among healthcare facilities. Poor quality of care has been a major contributor to morbidity and mortality, thereby shifting attention to quality of improvement approaches. The most critical period for saving maximum number of maternal and newborn lives and preventing stillbirths is during childbirth (WHO)

WHO sees a future in which "Every pregnant woman and newborn receives high quality care throughout pregnancy, childbirth and the postnatal period.

It is accepted that the level of perinatal care provided in a health facility is dependent upon the:

- Resources /facilities available at the particular health facility

- Experience of medical staff (obstetric, anaesthetic and paediatric), midwives and neonatal nursing staff available

- Availability of other services and facilities to manage the identified and potential complications

The assessment needs of every patient would be identified which includes identifying danger signs in pregnant women that would guide in determining what type of care is to be rendered and this care is adequately coordinated among the relevant departments through the development and implementation of appropriate processes.

This standard is for the purpose of improving the quality of care for mothers and newborns before, during and after childbirth. It centres on individuals, emphasizes the fundamental rights of the mother, new-born and families, promotes birthing practices that recognise women's preferences and needs, focuses on humanistic care and prompt referral of high risk patients.

MCH 1.3: Every woman and new-born with condition(s) that cannot be dealt with effectively with the available resources in a health facility is appropriately referred without delay.

MCH 1.3.1 Every woman and newborn is appropriately assessed on admission, during labour and in the early postnatal period and a determination made without delay whether referral is required.

MCH 1.3.2. The health facility establishes processes for referral or transfer that can be implemented without delay at any time.

MCH 1.3. 3.There is appropriate information exchange and feedback to and amongst all relevant healthcare staff concerning every woman and new-born that requires referral or transfer.

**MCH 1.4: Every woman in labour receives appropriate evidence-based care**

**Intent**

Given that most maternal and new-born deaths occur around the time of delivery, it is important that optimum care should be provided around the time of labour and delivery to assure a safe outcome for both mother and baby. Such care should be provided in the context of respectful maternal care which promotes a good experience for the labouring woman and becomes an incentive for institutional delivery. High-impact evidence-based interventions should be prioritised while obsolete procedures should be abandoned

MCH 1.4.5 Every woman is offered the option to experience labour and childbirth with the companion of her choice.

MCH 1.4.6 All women are given information about interventions and allowed to make informed choices about the care and services they receive, and outcomes are clearly explained.

**MCH 1.5: Policies, procedures, and guidelines to reduce the likelihood of harm related to maternal hemorrhage are established.**

**Intent**

Assessing patients' risks for hemorrhage allows the team to identify higher- risk patients and be prepared. The risk of hemorrhage may change during a patient's stay depending on the clinical situation.

Establishing defined procedures to manage patients experiencing severe hemorrhage and ensuring those caring for them function as a seamless team to deliver the needed care is critical. In addition, ensuring all supplies required to treat hemorrhage are available and easily accessible in one place is essential to minimizing delays in treatment.

To be able to manage patients experiencing severe hemorrhage adequately, it is important to have defined and established procedures for responding to the situation which are known to members of the care team. This will reduce the risk of delays and errors. The defined procedures include (but are not limited to):

Use of an evidence-based tool for identification and treatment of hemorrhage

The use of evidence-based emergency response medication(s) that are immediately available on the unit

Required response team members and their roles in the event of severe heemorrhage

How to activate the response team and procedures for obtaining blood including a blood bank plan and how to initiate the procedures for massive transfusion

Guidelines on when to consult additional experts.

Guidelines for when to consider transfer to a higher level of care or another organisation.

Having quick access to appropriate supplies and emergency medications to treat haemorrhage is critical when patient emergencies occur. Emergency cabinets, carts, bags, or boxes can be used for this purpose to minimize delays in treatment.

They should contain the following at a minimum:

g. Emergency hemorrhage supplies as determined by the organisation based on guidelines or recommendations of recognized bodies e.g. W.H.O.

h. The organisation's approved procedures for responding to and managing severe haemorrhage.

Using defined processes during emergencies has been shown to improve adherence to recommended processes of care. Each organisation should complete an assessment to determine the number of kits needed and the location to store them for easy access.

Severe postpartum haemorrhage does not occur very often. Care teams therefore need to prepare and practice to function optimally in a true emergency. This involves conducting drills and the use of simulations. Health facilities should ensure drills involve representation from each discipline identified in the organisation's hemorrhage response procedure and include a team debrief after the drill to identify key findings and improvement opportunities. Processes to communicate key findings and improvement opportunities to all pertinent staff and providers should be established. In addition, a process to follow-up on all recommendations to improve identified opportunities should be put in place.

Women need to know what symptoms are considered dangerous, when to speak up and call for help during hospitalization, and when to seek care after discharge. Women should understand what amount of bleeding they should be concerned about and possible signs of internal bleeding that should prompt them to call for help or seek care even if no bleeding is seen (e.g., abdominal pain, extreme tiredness, dizziness or rapid heartbeat.) Education should be provided in person and augmented with written materials which patients and their families can refer to in their own time. At a minimum, education should include:

Signs and symptoms of postpartum hemorrhage during admission that alert the patient to seek immediate care.

Signs and symptoms of postpartum hemorrhage after discharge that alert the patient to seek immediate care post-discharge.

When to schedule a post-discharge follow-up appointment

MCH 1.5.1. Complete an assessment for every patient using an evidence-based tool for determining maternal hemorrhage risk during the antenatal period, on admission in labour and on admission to the postnatal ward

MCH 1.5.2. Evidence-based procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage that includes a- h below are collaboratively developed by a developed by a multidisciplinary team that includes representation from obstetrics, anesthesiology, nursing, laboratory, and blood bank.

MCH 1.5.3. Each obstetric unit has a standardized, secured, dedicated hemorrhage supply kit that must be stocked and readily available as described in g-h in the intent.

MCH 1.5.4. Health facilities should conduct drills at least bi-annually to determine system issues as part of on-going quality improvement efforts.

MCH 1.5.5. Health facilities should establish criteria that automatically generate a quality improvement review to evaluate the effectiveness of the care, treatment, and services provided.

MCH 1.5.6 Health facilities ensures review of hemorrhage cases that meet the established criteria.

MCH 1.5.7 Health facilities establish a process to disseminate key findings and improvement opportunities to all pertinent staff and providers

MCH 1.5.8. Provide education to patients (and their families/caregivers) that covers i - k in the intent as a minimum.

MCH 1.5.9. Provide role-specific education to all staff and providers who treat pregnant and postpartum patients about the organisation's hemorrhage procedure. At a minimum, education occurs at orientation, whenever changes to the processes or procedures occur, or annually.

**MCH 1.6: Policies, procedures, and guidelines to reduce the likelihood of harm related to maternal severe hypertension/preeclampsia are established**

**Intent**

According to studies done, delays in the diagnosis and treatment of severe hypertension/preeclampsia and inadequate treatment of severe hypertension/preeclampsia are linked with adverse maternal outcomes.

It is vital to provide education for healthcare providers on how to measure accurate blood pressures, recognize severe hypertension/ preeclampsia, and provide evidence-based treatments to lower blood pressure in a safe and timely manner. Having clear guidelines and procedures in place should reduce failures to recognize and treat severe hypertension/preeclampsia.

These include:

The use of an evidence-based set of emergency response medications that are stocked and immediately available on the obstetric unit

The use of seizure prophylaxis

Guidelines on when to consult additional specialists

Guidelines on when to use continuous fetal monitoring

Guidelines on when to consider emergent delivery

Guidelines on when to transfer the patient to a higher level of care or to another health facility

Criteria for when a team debrief is required

To improve the response in the event of an emergency, multidisciplinary drills should be conducted to give healthcare team members the opportunity to practice the appropriate response and identify system issues in a controlled environment. It is crucial to have members from as many disciplines as are usually involved in the care of patients in this situation available during drills to truly be able to test each level of the emergency and identify areas of improvement. Drills should be conducted bi-annually at the minimum.

Organisations that manage patients with emergencies more frequently should endeavor to conduct debriefs after managing patients to identify opportunities for improvements. A process to follow-up on all recommendations to improve identified opportunities from drills or actual situations should be established.

Women need to know what symptoms are considered dangerous, when to speak up and call for help during hospitalization, and when to seek care after discharge. Education should be provided in person and augmented with written materials which patients and their families can refer to in their own time. At a minimum, education should include:

Signs and symptoms of severe hypertension/preeclampsia during admission that alert the patient to seek immediate care.

Signs and symptoms of severe hypertension/preeclampsia after discharge that alert the patient to seek immediate care.

When to schedule a post-discharge follow-up appointment

MCH 1.6.1 Develop written evidence-based guidelines and procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes a – g in the intent.

MCH 1.6.2 Develop written evidence-based guidelines and procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes a – g in the intent.

MCH 1.6.3 Conduct multidisciplinary drills at least bi-annually to determine system issues as part of ongoing quality improvement efforts.

MCH 1.6.4 Health facilities should establish criteria that automatically generate a quality improvement review to evaluate the effectiveness of the care, treatment, and services provided for severe hypertension/preeclampsia cases.

MCH 1.6.5 Review severe hypertension/preeclampsia cases that meet criteria established by the health facilities to evaluate the effectiveness of the care, treatment, and services provided to the patient during the event.

MCH 1.6.6 Health facilities establish a process to disseminate key findings and improvement opportunities to all pertinent staff and providers.

MCH 1.6.7 Provide education to patients and their families/caregivers which covers h - j in the intent as a minimum.


MCH 1.6.8 Provide role-specific education to all staff and providers who treat pregnant/ postpartum patients about the health facility 's evidence-based severe hypertension/preeclampsia procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or annually.