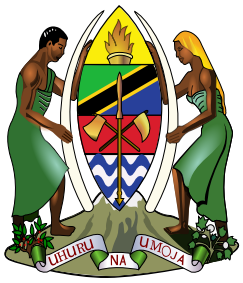

The United Republic of Tanzania

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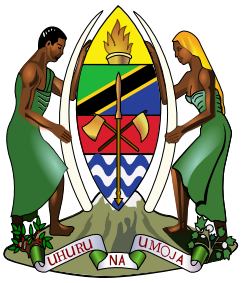

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Foreword

The need to strengthen, Regional Referral Hospital Management became inevitable towards and in the Health Sector Reform era. The reforms initiative advocated strongly on instituting changes in management authority, broadened financial options, and strengthened management in resource utilization (financial, human, and infrastructure). Nevertheless, this yearning objective could not be achieved effectively. On the same need, Ministry of Health Community Development Gender Elderly & Children (MoHCDGEC) requested for Technical assistance to strengthen the Regional Referral Hospitals management from JICA in 2015.

The Guideline on Internal Supportive Supervision (ISS) and External Hospital Performance Assessment (EHPA) is one of the deliverables of the Project for Strengthening Regional Referral Hospital Management (RRHMP) supported by the JICA Technical assistance. Certainly, the ISS/EHPA Guideline has come at an opportune time when the need for strengthening Region Referral Hospital (RRH) is higher than ever before. The development and pre-testing of both guides/tools has been participatory, engaging wide range of stakeholders. The ISS/EHPA document has two important guidelines:

1. Guideline for Internal Supportive Supervision which is intended for use by the Regional Referral Hospital Management Teams (RRHMTs) to monitor closely and on quarterly basis the priority interventions planned in CHOP to address the requisites of the Regional Referral Hospital. The guide is also attached with the ISS tool that enables the users to conduct the intended supportive supervision in a standardized measure;

2. Guideline for External Hospital Performance Assessment geared at providing guidance to RHMT to assess the performance of RRHs. Likewise, the guide is appended with the EHPA tool and other important instruments.

It is sufficient to clearly convey the importance of this guide not only to both RRHMT and RHMT but also to all interested stakeholders. This guide provides good and comprehensive reference as well as standard tool (ISS) for monitoring progress of implementation and achievement of Hospital key indicators in a supportive manner. Moreover, part two of the document, provides the needful in terms of measuring performance of the RRHs. This is the first document with standard tool for assessing performance of the RRHs. The guide is therefore very useful in providing a good insight of the prevailing situations of the RRHs in the country; but also, opportunity to governance systems of the RRHs to ensure that through gaps realized by ISS and EHPA, the hospital functions and addresses the real fundamental requirements of the RRH and furthermore, the needs of the community/ clients.

I'm positively convinced, if all instructions are observed in the guide and the tools and correctly used, the issue of having evidence - based CHOP from all RRHs is definite. This has been proved by the lessons learnt from the results of EHPA Baseline survey that was conducted to all RRHs by their respective RHMTs who were trained on the usage of the tools in June 2017. The Baseline Survey was conducted from 7th June to 7th October 2017.

I therefore call upon RHMT, RRHMT, and all stakeholders to use this guide effectively and make use of findings obtained from the analysis of the monitoring and assessment of the tools attached herein.

Prof. Muhammad Bakari Kambi
Chief Medical Officer
Ministry of Health, Community Development, Gender, Elderly and Children

Acknowledgement

The development of this Guideline has taken a longer time than expected. This is because, its development, involved collecting inputs from a range of different stakeholders: RRHMTs and RHMTs from different regions, Officers from MoHCDGEC, PO-RALG, and Projects focusing on quality improvement and with performance assessment tools. This kind of involvement was also observed in piloting the ISS and for the EHPA up to carrying out the Baseline survey in the 28 Regional Referral Hospitals. With this amount of energy, inputs, investments from all stakeholders, the ministry finds it difficult to thank every individual by name. The ministry therefore appreciates the effort made by all who participated in one way or another at any stage of developing this guideline. We are grateful to them all.

In addition, the ministry would like to express its appreciation to the team that coordinated the whole processes from development to completion of this document; without their commitment, hard work, and endless efforts this work would not be possible. This includes: Dr. Mutagwaba R.D Coordinator Regional Health Services, working teams from DHQA, and DCS. Their coordination effort from their departments is worth appreciating.

The financial and technical support that made this work possible came from the Government of Japan through JICA. The MoHCDGEC would like to register its utmost appreciation to JICA for their continued assistance that targets improving delivery of quality health care services in the country.

Lastly, but not least, the Ministry is grateful to RRHMP team for their efforts and endurance in stirring the process, but also for the continued input that resulted into this important Guideline particularly, Fares Masaule, Senior Technical Advisor; Hospital Planning Expert, Mr. Shuichi Suzuki; and Chief Advisor, Dr. Hisahiro Ishijima.

Edward Mbanga
Ag. Director, Policy and Planning
Ministry of Health, Community Development, Gender, Elderly and Children

Acronyms

The common abbreviations for conditions such as ARI, HIV, AIDS, TB, are not repeated here;

APHTA	Association of Private Health Facilities in Tanzania
CCHP	Comprehensive Council Health Plan
CHF	Community Health Fund
CHMT	Council Health Management Team
CHOP	Comprehensive Hospital Operational Plan
CMSS	Regional Administration and Local Government
CoHSASA	Council for Health Service Accreditation of Southern Africa
CRHS	Coordinator, Regional Health Services
CSO	Civil Society Organization
CSSC	Christian Social Services Committee
DMO	District Medical Officer
DMSS	District Management Supportive Supervision
FBO	Faith Based Organization
FEFO	First Expiry First Out
FIFO	First In First Out
GIZ	Gesellsehaft Fur Internationale Zusammenarbeit
GSS	General Supportive Supervision
JICA	Japan International Cooperation Agency
HBF	Health Basket Fund
HBG	Health Block Grant
HMIS	Health Management Information System
HMT	Hospital Management Team
HPAT	Hospital Performance Assessment Tools
HPAR	Hospital Performance Assessment Report
HPT	Hospital Planning Team
HRH	Human Resource for Health
HS	Health Secretary
HSR	Health Sector Reform
HSSP	Health Sector Strategic Plan
ICT	Information and Communication Technology
ISS	Internal Supportive Supervision
KPI	Key Performance Indicator
LGA	Local Government Authority
LGDG	Local Government Development Grant
M&E	Monitoring and Evaluation
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MO i/c	Medical Officer in charge
MoHCDGEC	Ministry of Health, Community Development, Gender, elderly and Children
MSD	Medical Store Department
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
NPEHI	National Package of Essential Health Interventions
NSGRP	National Strategy for Growth and Reduction of Poverty

NSSF	National Social Security Fund
OBS&GYN	Obstetrics and Gynaecology
OC	Other Charges
OPD	Outpatient Department
OPRAS	Open Performance Appraisal System
PAI	Pharm-access International
PE	Personal Emoluments
PHC	Primary Health Care
PO-RALG	President Office Regional Administration and Local Government
POA	Plan of Action
PPM	Planned Preventive Maintenance
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality Improvement Team
QPR	Quarterly Progress Report
RAS	Regional Administrative Secretariat
RHM2	The project for strengthening the Regional Health Management Teams in collaboration with JICA
RHMT	Regional Health Management Team
RMSS-C	Regional Management Supportive Supervision for CHMTs
RMSS-H	Regional Management Supportive Supervision for Regional Referral Hospitals
RRH	Regional Referral Hospital
RRHAB	Regional Referral Hospital Advisory Board
RRHMT	Regional Referral Hospital Management Team
RRHMP	the Regional Referral Hospitals Management Project
RMO	Regional Medical Officer
RRH	Regional Referral Hospital
RS	Regional Secretariat
SS	Supportive Supervision
SWCA	Stepwise Certification towards Accreditation
TGPSH	Tanzanian German Programme to Support Health
TQM	Total Quality Management
WIT	Working Improvement Team

Chapter 1: Introduction

1.1. Background

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) and President Office - Regional Administration and Local Government (PO-RALG) are striving at enhancing hospital governance and management. Several MoHCDGEC Policy documents emphasize the importance of strengthening Regional Referral Hospital Management Teams (RRHMTs), as a platform towards strengthening Regional Referral Hospitals' governance and management and consequently improving the quality of services provided by these hospitals. These policy documents include the National Health Policy (2007), Health Sector Strategic Plan IV (2015-2020), and Primary Healthcare Development Plan (in Swahili short form is "MMAM").

MoHCDGEC will support Regional Referral Hospitals (RRHs) in prioritizing and planning their hospital interventions based on promotive, preventive, curative and rehabilitative needs for hospital services. Supportive supervision is one of the effective approaches to monitor health services provided at hospitals and improving their performance through technical advices provided on the spot. The first National Primary Health Care (PHC) Supervision Guidelines, developed in 1999 and revised in 2010, aimed at integrating various supervision guidelines to remove fragmented efforts in the supervision. Currently, National Supportive Supervision Guideline is widely used at zonal, regional and district level.

Central Management Supportive Supervision (CMSS) was developed to oversee the function of Regional Health Management Teams (RHMTs) towards RRHMTs and Council Health Management Teams (CHMTs). MoHCDGEC in collaboration with Japan International Cooperation Agency (JICA) through the project for strengthening the Regional Health Management Teams (RHM2) developed the guideline for Regional Management Supportive Supervision for Regional Referral Hospitals (RMSS-H) in 2014.

Following the achievements acquired and recommendations given in the report of the terminal evaluation of RHM2 project (2014), the need of capacity building of RRHMTs was identified. Hence, the Regional Referral Hospitals Management Project (RRHMP) started in May 2015. MoHCDGEC and PO-RALG agreed that Internal Supportive Supervision (ISS) and External Hospital Performance Assessment (EHPA) Tools for monitoring the progress of planned activities in Comprehensive Hospital Operation Plan (CHOP), productivity and quality of services provided at RRHs should be developed.

1.2. Objectives of the Guideline

Main objective of the guideline is to have clear guidance for RHMT and RRHMT to monitor and assess the hospital performance with the standardized M&E tools in view of improving quality and safety of health services.

Specific objectives are:

- To provide internal supportive supervision tool/checklist, and how to use it at RRHs
- To provide assessment methodology of external hospital performance assessment tools to RHMTs and relevant organizations.
- To enable the users improving hospital planning using Key Performance Indicators (KPIs) in the CHOP
- To provide guidance on reporting and dissemination of the ISS and EHPA results to stakeholders

1.3. Using the guidelines

1.3.1. Users of the guidelines

The main users of this guidelines are RRHMT and RHMT. The guideline will be utilized for implementation, analysis and reporting of the internal supportive supervisions and externa performance assessments. However, guideline can also be used by all healthcare providers, managers and other stakeholders as a reference for improving hospital performance. The supervisors from central level may also use the guideline for implementation, verification and follow up of the internal supportive supervisions and external hospital performance assessments, conducted by RRHMT and RHMT.

1.3.2. How to use the guidelines

This guideline is divided into three chapters for easy understanding of the contents of the guideline by implementers.

1) Chapter 1 is composed of Background information related with supportive supervision and assessments, explanation of guideline composition, and clarification of relationship among planning cycles, internal supportive supervision and external assessment
2) Chapter 2 is composed of guidance on how to conduct Internal Supportive Supervision (ISS) and its tools and checklists.
3) Chapter 3 is composed of guidance on how to conduct External Hospital Performance Assessment(EHPA), and its tools and checklists.
4) Annex is composed of necessary tools and checklist to support the implementation of ISS and EHPA.

The users of this guideline are strongly advised to observe the following tips:

- Read Chapter 1 and 2 to understand the necessity of internal and external monitoring and evaluation activities and adopt the both activities and instructions that are explained in each section in the Chapters. It is recommended to assess yourself on the understanding of the content before you proceed to the next procedure.
- Orient yourself with the tool and annexes by reading repeatedly every part of the assessment checklist and link with the content and instructions in the annexes.
- Make sure you understand very well the relationship between the two tools i.e. ISS and EHPA and their importance in the development of CHOP.

1.4. PDCA cycle with ISS and EHPA

ISS and EHPA are not rating tools of RRH, and they are the tools for effective and efficient management of RRH. RRH should be managed well based on PDCA cycle. Principally, CHOP must be developed annually based on the lessons learnt from ISS and quarterly progress report for CHOP. Additionally, the findings from EHPA also should be utilized for development of CHOP as evidence-based planning by RRHMT.

The plan should be realistic, logical and linking with the available resources with the health needs. In terms of planning and management, planning is not only developing one-year work design but also necessary for improving frequently based on the achievement, data, information and lessons learned from the previous year. Those lessons learned will be provided by regular implementation of ISS and EHPA. To achieve that, Plan, Do, Check and Act (PDCA) cycle is one of the most famous and useful cycles to describe adequate planning cycle. PDCA cycle should be rotated with the strong evidences. Rotation of PDCA cycle includes the setting priorities, implementing the plan, monitoring the process, and involves evaluating the achievements and findings through ISS and EHPA.

The outcome of achievements of the activities in previous year will be measured by the findings of ISS and EHPA. This means, experiences and data from the previous year are the most important resources to develop the next financial year of CHOP. Meaning of applying PDCA cycle to the RRH management team is as follows;

Plan

Each RRH is supposed to develop CHOP every year (annually). RRHMT are required to develop the CHOP based on the previous year achievements, experiences and expenditures. It is necessary to check whether allocated budget was the same as planned budget. It is important that RRHMT confirms what to omit when ceiling is low and asked to revise the budget plan.

Do

RRHMT implements activities listed in CHOP. During the implementation of CHOP, **ISS** needs be conducted quarterly to monitor the progress of the planned activities.

Check

It is necessary to evaluate the achievement of the activities planned in CHOP. The evaluation can be done by **EHPA** as well as improvement of Key Performance Indicators in CHOP.

Act

Based on the assessment results and outcome of the activities, it is necessary to identify weakness and strengths. Then, countermeasures are necessary to improve the challenges and weakness points through 5S-KAIZEN activities. It is also important to prioritize the actions to be taken and, to reflect those actions into next year's CHOP.

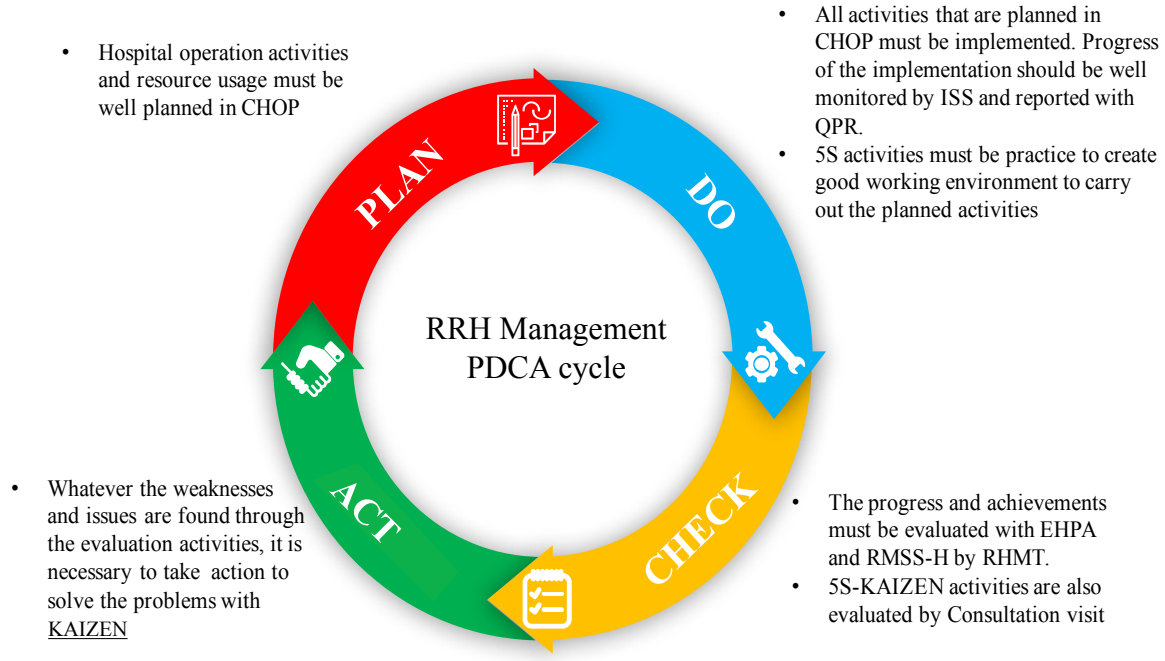


Figure 1-1: RRH management by PDCA cycle with ISS and EHPA

It is important for RHMTs and RRHMTs to clearly understand the concept explained in the above. Base on the RRH Management on PDCA cycle, CHOP is used in "PLAN" stage to see the "Inputs" to operate the hospital. Then, in the "DO" stage, all activities that are planned in CHOP must be implemented. Moreover, 5S activities and standardization activities that are established in KAIZEN (QC story) must be followed in the "DO" stage. Progress of the implementation should be well monitored by ISS and reported with QPR, and situation of 5S-KAIZEN-TQM implementation need to be monitored for the "Process" monitoring. "CHECK" stage is to evaluate the achievements though Outputs and outcomes. Therefore, evaluation tools such as EHPA, M&E sheet for implementation of 5S-KAIZEN-TQM need to be used to evaluate the hospital performance. In the "ACT" stage, if the weaknesses or problems are identified during the evaluation, RRHMTs need to take action to change the situation better with KAIZEN activities.

Chapter 2: Internal Supportive Supervision (ISS)

In this Chapter, Internal Supportive Supervision (ISS) for RRHs is well elaborated and provides technical guidance to RRHMTs to conduct Internal Supportive Supervision regularly.

2.1. Conceptual framework of ISS

2.1.1. Supportive Supervision in the Health Sector

Supportive supervision is referred to as a process which promotes quality of outcomes by strengthening communication, identifying and solving problems, promoting team work, and providing leadership for supporting to empower health providers to be able to monitor and improve their own performance[1]. Concept of ISS has been drawn from the following Supportive Supervision Framework in Health Sector.

(1) National level
MoHCDGEC has been conducting managerial Supportive Supervision (SS) for National, Zonal Referral, Specialized hospitals and RHMTs. However, under the new structure of regional health system, MoHCDGEC are now responsible to conduct SS to National, Zonal Referral, Specialized hospitals and RRHs, SS aims to deliver the national policy and programs, to monitor the functions and performances of different level of the hospitals based on annual plans.

(2) Regional level
Managerial supportive supervision at regional and council level is the responsibility of RHMT. The aim of the SS is to ensure the deployment of health policies and guidelines to RRHMT and CHMT. Supportive Supervision to RRHMT is referred as RMSS-H and to CHMT is referred as RMSS-C. Usually, above mentioned SS is done quarterly.

(3) Council level
The council is the focal point for the promotion of the health policy and the health interventions. CHMT are also on quarterly bases expected to conduct supportive supervisions to health and social welfare facilities in the council.

2.2. Rationale of ISS

RMSS-H is primarily a managerial supportive supervision and the tool used to conduct RMSS-H has been developed to oversee managerial functions of hospital management teams. In this regard, RMSS-H, has not been sufficient to improve the performance of RRHs because the overall core functions of RRHs are not adequately covered in the RMSS-H. Thus, ISS to respective departments/units is necessary to enhance self-assessment of hospital performance and for effective provision of services. Furthermore, ISS is expected to improve the managerial capacity of RRHMTs, in enhancing data collection[2], developing CHOP, monitoring activities and financial management.

The ISS should be conducted by RRHMT and RRHMT needs to provide feedback to their hospital staff. Results of the ISS are filled in the self-assessment tool and reported quarterly to MoHCDGEC and copied to RHMT with. Based on the results of self-assessment by RRHMT, MoHCDGEC will organize a team that may include members of RHMT and visit RRH. The team will check the validity of self-assessment through observation, data review and interviews as external hospital performance assessment. The structure of supportive supervision for RRH performance is as follows:

1 National Supportive Supervision Guideline for Quality Healthcare services 2010
2 Collected data needs to be accurate, complete, timely, etc.

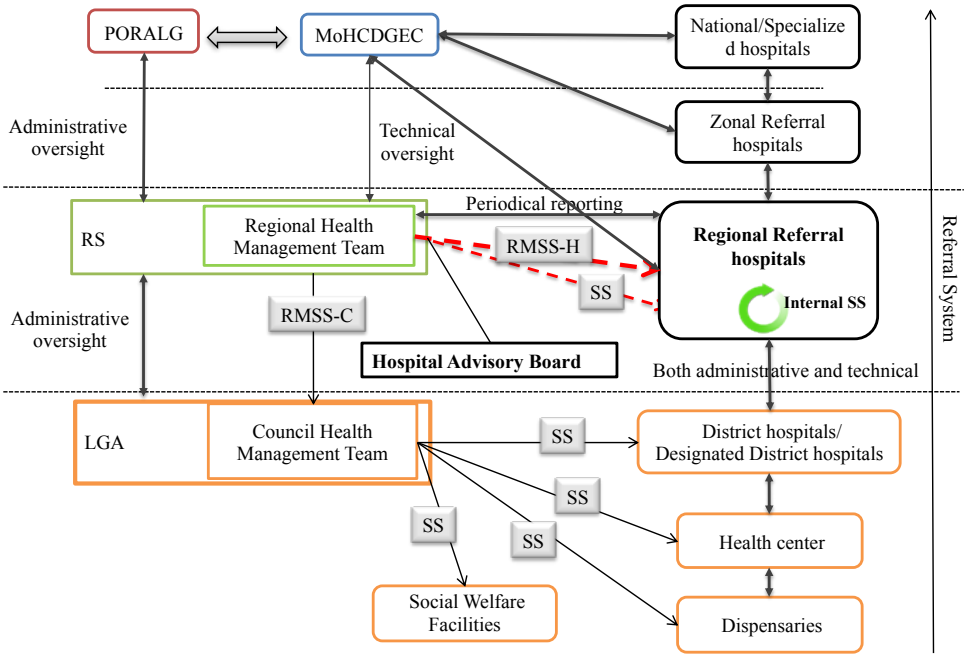


Figure 2-1: Structure of Supervision for RRH

2.3. Areas of ISS

There are various models for assessment of quality of care. In this guideline, the areas for assessment are based on the Donabedian's model (1980)[3], to monitor the progress of the activities at RRHs. Details of ISS checklist is in Annex for Chapter 2-1. The ISS checklist is composed of eight areas. Each area has related Key Performance Indicators (KPIs), which could be found in Annex A-2. However, the numbers for related KPIs are inserted under the details of each area. Details in the ISS checklist covers the following areas:

2.3.1. Area 1 Leadership and Governance

There are six (6) items that need to be checked in this area. Among the items to be checked in this area are good leadership of the hospital management as well as department levels.

2.3.2. Area 2 Annual planned activities

There are three (3) items that need to be checked in this area. The items to be checked in this area are participatory development of CHOP, implementation of planned activities, awarding and recognition towards QA/QI activities.

2.3.3. Area 3 Financial status

There are seven (7) items that need to be checked in this area. Among the items to be checked in this area are; regular reporting on financial management, revenue collection issues such as exemption and health insurance, etc.

2.3.4. Area 4 Human resource for Health

There are nine (9) items that need to be checked in this area. Among the items to be checked in this area are HRH management, such as duty roster and job description, motivation of staff, staff safety and appraisal issues.

2.3.5. Area 5 Health Commodities and Medical Supplies

There are seven (7) items that need to be checked in this area. Among the items to be checked in this area are availability, accessibility, storage methods of commodities and medical supplies.

3 On the Donabedian's model, structure, process and outcome are key areas for evaluating hospital

2.3.6. Area 6 Services provision and quality

There are eight (8) items that need to be checked in this area. Among the items to be checked in this area are readiness of service provision, availability of standard operating procedures, client satisfaction, safety issues, QI implementation structures and its functionality.

2.3.7. Area 7 Physical assets

There are eight (8) items that need to be checked in this area. Among the items to be checked in this area are functionality of utilities in the hospital, work place safety, condition of buildings and maintenance of equipment

2.3.8. Area 8 Hospital environment

There are twenty-eight (28) items that need to be checked in this area. Among the items to be checked in this area are hospital premises, external environment, waste management and incinerator are among the list.

2.4. Frequency and Duration of ISS

ISS should be conducted by RRHMT in every quarter. The ISS results are then reported together with the CHOP Quarterly Progress Report (QPR). ISS has linkage with Regional Managed Supportive Supervision for Health (RMSS-H) and External Hospital Performance Assessment (EHPA), conducted by MoHCDGEC. or in collaboration with RHMT. The results of ISS are submitted together with CHOP Quarterly Progress Report (QRP) to MoHCDGEC for assessment/ verification and preparation for the next EHPA. It is therefore, recommended ISS be conducted by two weeks before the submission date of QPR so that the RRHMT have ample time to analyse the results and compile report read for submission. The CHOP QPR and ISS are also used by MoHCDGEC for planning and policy decisions making (See Figure 2-2).

Table 2-1: Recommended schedule for ISS versus QPR

	Deadline of conducting ISS	**Deadline of QPR submission**
1st Quarter	October 01	October 15
2nd Quarter	January 01	January 15
3rd Quarter	April 01	April 15
4th Quarter	September 01	September 15

RRHMT should develop the schedule for quarterly ISS, which shows date of ISS, places/units/sections to be visited and responsible team members. The schedule should be in written note and available to all team members. The prepared schedule should avoid conducting supervision work when the target department is congested: such as early morning at OPD, elective operation in the operation theatre, etc. It should also observe that at least one and half hour is necessary for supervising one department including interviewing, filling checklist and feedback to the target department.

Hence, the duration to conduct ISS in RRH should not exceed four days. Before giving the feedback to the hospital staff, RRHMT must share the ISS results among the ISS teams themselves and discuss results and way forwards.

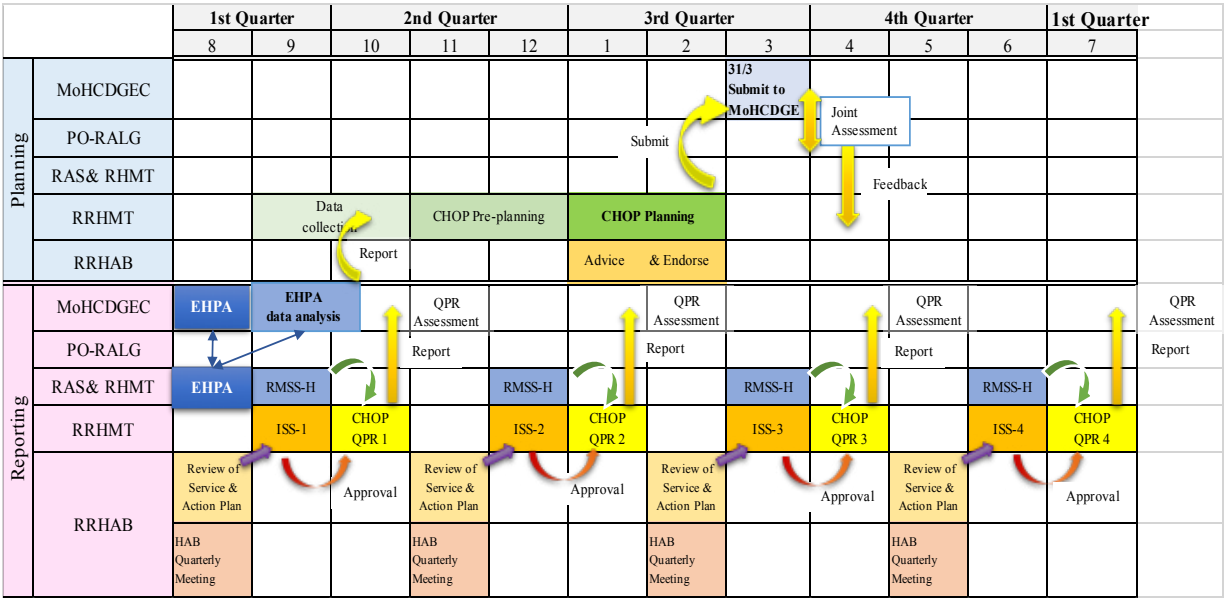


Figure 2-2: Frequency of ISS and EHPA, and linkage with other key activities

2.5. Implementation of ISS

ISS should be conducted under systematic process. As a system, proper planning and preparation are important. Before actual commencement, RRHMT should consider: timing, composition of supervision team, competencies of the team members, documentation, record keeping and so on. The following is a step by step process for preparation and implementation of ISS.

Table 2-2: ISS Implementation Steps and Schedule

Step	Action	Responsible	Deadline
Step 1	Develop schedule for ISS	RRHMT	Two weeks before execution of ISS
Step 2	Compose supervision team	RRHMT	One week before execution of ISS
Step 3	Orientation of supervision team	RRHMT	Before execution of ISS
Step 4	Preparation for ISS	Each target department	Before execution of ISS
Step 5	Conduct ISS	Supervision team	Within 4 days 1-1.5 hours for each target department
	5-1 Courtesy to In-charge		
	5-2 Interview		
	5-3 Document review		
	5-4 Physical condition observation		
	5-5 Brief feedback		
	5-6 Score checklist		
Step 6	Analysis and compilation of ISS results	Supervision team	Within 3-4 hours
Step 7	Feedback to RRHMT	Supervision team	One week after execution of ISS
Step 8	Submit report to RRHAB	RRHMT	Before submitting CHOP QPR to RHMT
Step 9	Submit report to RHMT (attach on CHOP QPR)	RRHMT	Same as CHOP QPR

Additionally, it is important to note that: strong commitment of the Medical Officer in-charge (MO i/c) in Quality service delivery promotes ISS. The ISS is not only for improvement of the current conditions at the RRH, but also, development of hospital plan, (CHOP). In this regard, MO i/c should understand how to implement PDCA

cycle of hospital management properly because, CHOP preparation and planning is one of the core activities in the Plan of the Hospital Management and ISS is a core activity for Do and Check of the hospital management.

Furthermore, it should be noted that Supportive Supervision is not replacement of audit or inspection; and therefore, supervisors must be very knowledgeable in ISS and provide technical advices on the spot for better improvement of observed conditions. Supervisor should mentor and coach how to improve the current situation through the supervision.

2.5.1. Composition of supervision team

The team will be formed by maximum of six (6) members depending on area to be supervised. Two (2) or three (3) members per supervision team are recommended because one member is an interviewer and another member is a note taker. The composition of the supervision team will include members with different competencies from RRHMT. Please note that co-opting of a member from other facilities at regional level to join the supervision team is recommendable when there is shortage of expertise.

2.5.2. Orientation of Supervision Team on ISS

It is important to be conversant with the processes of conducting ISS, especially the supervision teams. Supervision teams should be knowledgeable on ISS tool, marking methods, criteria and KPIs. From this view, the RRHMT should organize pre-orientation sessions on the tools, existing and available technical guidelines, standards, as well as how to analyse results and to keep record for the supervision teams. The pre-orientation is also of paramount importance for the team members to understand the recommendations from the previous ISS to monitor progress of the previously agreed interventions. (For important guidelines, manuals and documents for ISS refer Annex for Chapter 2-3)

2.5.3. Competencies of supervisors

Supervisors who conduct ISS should be equipped with the following competencies:

- Supportive: good facilitators, coaches or mentors; supportive to staff, not inspectors
- Familiar and having updated knowledge on hospital management and supervision areas
- Committed, responsible and having strong interpersonal interaction skills
- Ability to motivate other staff
- Ability to offer empathy and support
- Ability to demonstrate a positive attitude and facilitate team work
- Open-minded and good listener on interviews
- Ability to give on spot solutions

2.5.4. Preparation in the target departments/units

Before commencing supervision, each target department/unit needs to prepare the required documents mentioned on the checklist (Annex for Chapter 2-3) for easy access.

2.5.5. Conducting ISS

The supervision team(s) should visit all departments to carry out ISS separately, using checklist. The supervision team (s) should remember that ISS is not auditing, inspection or fault-finding. Conducting ISS in “supportive manner” will help supervisors to carry out the tasks and establish a good working relationship with department members.

At first, supervision team(s) pays courtesy call to the person in-charge of the department, and then ask the in-charge to assign an interviewee for ISS. The supervision team(s) should proceed interviewing the assigned staff using the checklist. Moreover, the team(s) should check the required documents and physical conditions listed

on the checklist. In the process, the team should give positive comments first on current situation, and then points out areas that need to be improved.

> *Please note that if you conduct ISS in negative mind-set, department staff will receive your advice with negative attitude.*

After site observation, supervision team(s) should check among the members whether all necessary indicators are scored or not. Cover form of the checklist shall be filled as soon after the site observation.

2.5.6. Analysis and compilation of ISS results

All ISS results must be analysed departmental wise, compiled and reported back to each department. Time for analysis and reporting is estimated at least three hours using ISS calculator (an excel format developed for easy calculation for the score of each area at each target department) and the provided report format. Let all departments know which areas need to be improved. All RRHMT members should keep records of the analysed and compiled departmental results.

Acquired data and information must be well recorded and kept for future ISS to monitor progress of departmental management. Hospital secretary shall take responsibility of keeping the records of ISS. Minimum time frame of keeping ISS results is 5 years.

2.5.7. Feedback to the hospital staff and RRHMT

(1) Feedback to the target department of ISS

The feedback takes place as soon as after ISS, and it is usually verbal and inform of discussion between the supervisors and the supervisees. In giving feedback, the supervision team should:

- Acknowledge the staff for tasks well done; general strengths and general weaknesses
- Ask for feedback from the staff according to the supervision process and tools
- Ask comments from the staff and RRHMT for problem solving and
- Stimulate staff to think on how to solve problems on their own

(2) Feedback to RRHMT

After the supportive supervision, the chairperson of the supervision team should share ISS results with the RRHMT through:

- Circulate the results of supervision to the members of RRHMT in advance
- Report and discuss the results of the supervision at RRHMT meeting

ISS should be a cycle of work as shown in Figure 2-3. ISS needs to be aligned with CHOP activities. Each stage has sub activities to carry out effective ISS as shown in Table 2-2. Previous ISS results must be well kept for next ISS so that RRHMT will be able to track the changes and improvement of hospital organization continuously.

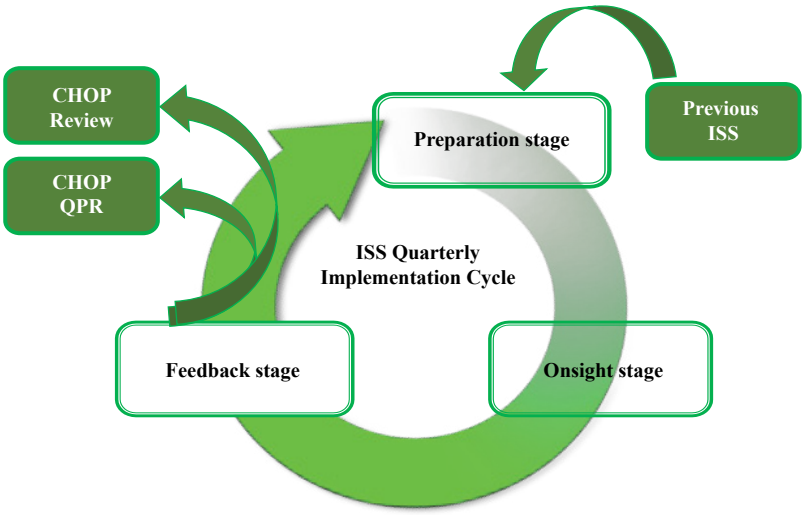


Figure 2-3: ISS cycle with CHOP

2.6. Reporting of ISS results

2.6.1. Internal reporting and dissemination of the results

After verification of assessment results, the supervision team should compile a comprehensive report, and thereafter, the RRHMT should disseminate the report to key and interested stakeholders. The report format is in Annex. 2-3

2.6.2. External reporting

The results of the ISS should be reported to the Regional Referral Hospital Advisory Board (RRHAB) for comments, inputs as well as record of progress on the implementation of Hospital planned activities in CHOP. The result is then compiled alongside with the CHOP Quarterly Progress Report (QPR). The CHOP QPR should also be submitted to RRHAB for endorsement before being submitted to MoHCDGEC for assessment. The reporting mechanism of ISS needs to be aligned with CHOP Reporting Mechanism.

2.7. Key Performance Indicators (KPIs)

Key Performance Indicators (KPIs) measure how well an organisation is performing against set targets or expectations. KPIs measure the performance by showing trends to demonstrate that improvements are being made over time. KPIs need to be reported on CHOP Quarterly Progress Report (QPR).

KPIs also measure the performance by comparing results against standards or benchmarking with other similar organisations. The measurement helps the organisations to improve their services through identifying where the performance is at the desired level and identifying where improvements are required. An example of KPIs used in healthcare is the numbers of patients that are waiting for more than six hours in the emergency department for admission to a hospital bed. KPIs are improved by the efforts of each department and through the ISS. Detail of KPIs is in Annex. A-2.

Annex for Chapter 2-1: ISS Checklist

Cover Page

Regional Referral Hospital Internal Supportive Supervision Checklist

Name of the RRH:
Date of ISS:
Name of Department:
Name of Interviewee:
Name of Supervisors/Title
1) (Title)
2) (Title)
3) (Title)

Area	***Strength (Area)***	***Weakness: (Area)***	***Recommendations: (Area)***
1			
2			
3			
4			
5			
6			
7			
8			

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
Area 1 Leadership and Governance								
1	Good leadership, teamwork and management is in place	Check availability of organogram, meeting schedule, minutes of meeting, follow up and feedback mechanism, internal supervision mechanism and conflict resolution is in place and adhered to. 3: Fully followed Checkpoints 2: Partly followed Checkpoints 1: No followed Checkpoints	*- Check availability of organogram, meeting schedule, minutes of meeting,* *- Ask to follow up and feedback mechanism, and internal supervision mechanism*	*All*				
2	Regular department/ward update of HRHIS and share it with HMT	Does your department/ward update regularly HRHIS and share it with HMT? 3: Available and updated 2: Available but not updated 1: Not available.	*- HRHIS*	*All (mutual check at HMT)*				
3	Responsiveness from head of sections	Percentage of implementation of instruction given by RRHMT Response of challenges noted at lower levels 3: Receiving proper instruction from RRHMT and giving proper response to lower level 2: Only one way (from RRHMT or to lower level) 1: No instruction	*- Interview to head of department*	*All*				
4	Transparency and openness	Top down and bottom up communication 3: There are top down and bottom up communication (all necessary information is shared in the department) 2: some information is not shared 1: No communication between head and staff	*- Interview to staff of department*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
5	Management of human resource for health	Human resource Information system is updated (Job description in place, Succession planning, Training plan, Promotion plan) 3: All systems are updated 2: There are all systems but not updated 1: No system	*Job description in place* *Succession planning* *Training plan* *Promotion plan*	*Administration*				
6	Effective Planning	There is effective mechanism of developing CHOP. 3: Three documents are in place 2: Two documents are in place 1: One or No document is there	*Policy document,* *Hospital Strategic plan,* *Hospital preparedness emergency plan*	*Administration*				
Area 2 **Annual Hospital Activities**								
1	Preparation, implementation of CHOP is participatory	Check evidence of participation in CHOP preparation and knowledge/ awareness of approved activities that are being implemented 3: There is evidence of participation in preparation and implementation 2: There is evidence of participation in either planning or implementation 1: They are only involved in implementation	*- Interview who and how involved into CHOP development* *- Minutes of CHOP meeting*	*All*				
2	Implementation of planned activities are monitored	Evidence of activity progress report, regular review meeting and action taken. 3: All are available 2: Only progress report is available 1: Review meeting was held or CHOP was no in Place	*- Report* *- Interview how and when planned activities are done*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
3	Availability of awarding or recognition ceremony/ events towards QA/QI activities	Check availability of awarding or recognition ceremony/events to increase staffs' motivation towards continuous implementation of QA & QI activities 3: Conducted periodically 2: Conducted occasionally 1: Not conducted	- *Report* - *Interview when and how the ceremony is done*	*Administration (QIT)*				
Area 3		**Financial Status**						
1	Monthly Hospital financial report feedback	Do you get Hospital financial report feedback on monthly basis? Check department/ward monthly minutes. 3: Financial report appeared in the minutes or elsewhere 2: Financial report appeared but no minutes and elsewhere 1: No financial report	- *Monthly minutes* - *interview when and how receive financial feedback*	*All*				
2	Availability and displayed price list for medicines and service charges in your department	Are the service and medicine charges found in the service provision area? 3: Price list is available, updated and found easily in the service delivery point 2: Price list is available but not updated 1: Price list is not available	*Medicine and services comprehensive price list*	*All*				
3	Awareness of National exemption guideline and its beneficiaries	Do you know the National exemption guideline and its beneficiaries? Mention at least 5 beneficiaries. Check if the exemption guideline is in place 3: At least 5 beneficiaries are listed 2: Some beneficiaries are listed 1: Not listed	- *Exemption guideline* - *Ask who is beneficiaries*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
4	Activities implemented based on approved budget at your departmental/ward	Is expenditure implemented based on approved departmental/ward plan? Check list of activities implemented according to department/ward plan. 3: 80% of the planned activities were implemented 2: 40% of the planned activities were implemented 1: Target not in place or in place but collection is Less than 40% of the planned activities	*- List of activities* *- Interview how and when the activities done*	*All*				
5	Availability of revenue collection agenda in departmental/ward meetings	Do you have an agenda in your meeting on how to improve revenue collection at your department/ward? Are there activities to improve revenue collections? Check department/ward activities that were suggested and implemented in the monthly minutes. 3: Financial activities appeared in the minutes or elsewhere 2: Financial activities appeared but no the minutes and elsewhere 1: No financial report	*- Financial report* *- Interview how to improve revenue collection*	*All*				
6	Wastage of the resources is concerned in the department (mechanism to reduce wastage of resources)	Are there means to reduce wastage of resources? Check department/ward activities that aim at reducing resource wastage. 3: At least five resource wastage mechanisms are in place 2: Some resource wastage mechanism is in place 1: No mechanism	*- Interview how to reduce resource wastage*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
7	Revenue collection (Regarding cost sharing, NHIF and others in your department/ward in the last three months	What is the trend of revenue collection (Regarding cost sharing, NHIF and others in your department/ ward in the last three months? 3: There was a target set and 80% of the target collection was achieved 2: There was a target set and 40% of the target collection was achieved 1: Less than 40% of the target collection was achieved or no target set	- *Financial report*	*NHIF Department*				
Area 4 Human Resource for Health								
1	Adequate of human resource	Check list, number of employees, their qualification and skill mix 1) Duty allocation is in line with qualification, 2) Job allocation is in accordance to qualification and skills 3: Fully followed Checkpoints 2: Partly followed Checkpoints 1: No followed Checkpoints	- *Attendance register* - *job allocation*	*All*				
2	Availability of duty roster in your department/ward duty roster	Is the duty roster available in your Department/ ward? Check duty roster if available. 3: Duty roster is available and updated 2: Duty roster is available but not updated 1: Not available	- *Duty Roaster*	*All*				
3	Adherence to duty roster in your department/wards	Is the duty roster in your department/wards adhered to? Check attendance register. 3: Attendance register corresponds to duty roster 2: Attendance register corresponds to duty roster partially 1: Attendance register does not correlate with duty roster	- *Duty roaster* - *Attendance register*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
4	Availability of staff motivation in your department/ ward	What are the available staff motivation in your department/ward? Check availability of any motivation initiatives. 3: At least 5 initiatives are listed 2: less than 4 initiatives are listed 1: Not listed	*- Interview at least one staff what kind of motivation initiatives is done (not necessarily financial motivation)*	*All*				
5	Availability of staff safety measures within the department/ward	Is the department/ward taking safety measures for its staff? Check if safety measures available per working processes in a specific department/ward. 3: Necessary safety measures are available and followed 2: Necessary safety measures are available but followed partially 1: Necessary safety measures are not available	*Check what kind of safety measures are available (hand washing facilities with soaps, provision of PEP services, electrical safety e.g. switches and fire fighting equipment*	*All*				
6	Percentage of OPRAS forms filled and submitted to HMT	What percentage of your staff already filled and submitted OPRAS forms to Head and head submitted to HMT? Check copy of OPRAS forms filled. 3: 80% of the staff present have filled and submitted OPRAS forms 2: 40% of the staff present have filled and submitted OPRAS forms 1: Less than 40% of the staff present have filled and submitted OPRAS forms	*- OPRAS forms (check the copies in the files)*	*All (mutual check at HMT)*				
7	Availability of training schedule in your department/ward	Do you know if there is training schedule/on job training in your department/ward? Check if the department has prepared its own training needs assessment check if there is on the job training e.g. weekly presentations, weekly Check training schedule available. 3: There is training schedule and adhered 2: There is training schedule and adhered partially 1: There is no training schedule	*- Training plan, schedule and report*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
8	Induction and orientation	Check if there is a system of orienting newly recruited employee in the department. 3: Orientation mechanism is equipped and followed 2: Orientation mechanism is equipped and followed partially 1: Orientation mechanism is not equipped	*- List of new staff oriented* *- Number of staff employed/transferred in* *- Interview how to conduct orientation to new staff*	*All*				
9	Task description are available	Does each staff have task description? Check availability of task description. 3: Task description displayed and updated 2: Task description displayed but not updated 1: Task description is not available	*-Task description*	*Administration*				
Area 5 **Commodity and Medical Supply**								
1	Availability of basic equipment at the department/ ward Basic equipment are available with good condition at department/wards	Is the basic equipment available at the department? Check the availability with condition of basic equipment. 3: Counts more than 80% of the basic equipment is good condition 2: Counts more than 40% of the basic equipment is good condition 1: Counts 40% or less of the basic equipment is good condition	*Physical Count of basic equipment*	*All*				
2	Effective and efficient stock management by adopting visual control methods	Are the visual control methods adopted for effective and efficient commodity management? 3: Visual control methods are adopted to all areas at where health commodities are stored, with clear instructions how to use the methods 2: Visual control methods are adopted to few areas at where health commodities are stored, with clear instructions how to use the methods 1: Visual control methods are limited area or not adopted	*Check colour coding, labelling, zoning, etc.*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
3	Availability and use of SOPs (Standard Operational Procedures) for commodity management	Check whether several SOPs for storage and issuing of health commodities are available in each proper place and used it for quality of services 3: The SOPs are put in respective proper areas and used well 2: Some of SOPs are prepared but not put in respective proper place 1: The SOPs are not in place and not used	*-SOP* *- Ask some contents of SOP to one staff*	*All*				
4	Accessibility of medicines/ medical commodities at the department/ward Medicines are accessible at departments/wards	Are the medicines/ medical commodities easily accessible? Visit storage area. 3: Easily accessible and well monitored 2: Accessible and not monitored 1: Locked and not easily accessible.	*Visit storage area.*	*Clinical Department*				
5	Minimum number of expired health commodity	Is there mechanism to minimize many expired medicines and medical supplies? 3: FIFO and FEFO is adopted to all areas at where health commodities are stored 2: FIFO and FEFO is adopted to few areas at where health commodities are stored 1: FIFO and FEFO is not adopted	*- Interview meaning of FIFO and FEFO.* *- Interview how do you prevent expiry*	*Clinical Department and Store*				
6	Medicines/medical commodities and medical supplies properly monitored in the past one month	Have you monitored medicines/medical commodities and medical supplies properly in the past one month? Check availability of drug control sheet, prescription register, ledger and description books. 3: Properly filled and correlate with Pharmacy and patient treated 2: Filled but does not correlate 1: Not filled	*Check availability of drug control sheet, ledger, dispensing book, prescription register and prescriptions.*	*Clinical Department (all) Other (commodity only)*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
7	Proper positions of all medicines, medical commodities and medical machines considering efficient work flow	Check whether medicines, medical commodities and medical machines are put in good order consideration with efficient work flow with clear indication labels. 3: All medicines, medical commodities and medical machines are in good order with clear indication labels 2: Some of medicines, medical commodities and medical machines are in good order with clear indication labels 1: All medicines, medical commodities and medical machines are not in good order	*Check work flow and compare to position of each items.*	*Clinical Department (all) Other (commodity only)*				
Area 6 Service Provision and Quality								
1	Working processes are adhered to standards	Check availability of pertinent SOPs and guidelines. Check physically whether the working processes/procedures adhere to SOPs and guidelines including record keeping. 3: SOPs are available (easily accessible), adhered to (displayed), and procedures are being done and recorded properly 2: SOPs are available but some procedures are not followed 1: SOPs are not available	*-SOP* *- Ask some contents of SOP to the staff*	*All*				
2	Mechanism of obtaining feedback from clients is in place	Check availability of suggestion box system, system for handling clients' complaints and exit interview. 3: These system is present and functioning 2: Some system is present but not functioning 1: The system is not present	*- Provide all possible means of collecting clients' complaints/ information, handling information and means of providing feedback* *- Exit interview*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
3	Presence of measures to ensure safety to workers and clients are in place	Check on presence of a system for risk management, documentation of accidents and medical errors and discussion on prevention of recurrence. Check on presence of schedule and reports on training on hazards prediction. 3: Fully followed Checkpoints 2: Partly followed Checkpoints or No documentation 1: No followed Checkpoints	*- Safety checklist (specific in every service provision area)* *- Interview how to utilize the checklist*	*All*				
4	Improvement activities by KAIZEN	Check any improvement activities by utilizing KAIZEN process (QC Story) to improve productivity, quality, cost, safety and delivery of services 3: KAIZEN activities are practiced continuously 2: Some KAIZEN activities were practiced before but are not continuously practiced 1: KAIZEN activities were not practiced yet	*- Record of KAIZEN activities*	*All*				
5	Availability of continuous education on Quality Assurance (QA) and Quality Improvement (QI) activities for the staff	Check availability of continuous education session; training, on the job training, introduction/orientation session etc. on QI&QA activities at section level 3: Conducted periodically (Scheduled and conducted) 2: Conduct occasionally (Conducted but not scheduled) 1: Not conducted	*- Training schedule*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
6	Availability of records on QA/QI activities	Check availability of any records on QA/QI activities; WIT meeting minutes, action plan for QA/QI, departmental/sectional training/orientation, photographic evidences etc. 3: All records on QA/QI activities are kept in the file specific for QA/QI at departmental/sectional level 2: Some of records on QA/QI activities are kept in the file specific for QA/QI at departmental/sectional level 1: No records on QA/QI activities are available	*- Record of QA/QI activities*	*All*				
7	Conducive environment for provision of health services (Medicine and commodities)	Check availability of adequate medicines and health commodities as per local made essential medicines and health commodities list 3: the list is available together with supplies at medium level of stock 2: the list is available but stock level is lower than medium level 1: the list is not available	*- List (standard tracer/ essential (locally provided) medicine/supplies)* *- Interview how to utilize the list*	*Clinical Department (all)* *Other (Commodities)*				
8	Conducive environment for provision of health services (Medical tools and equipment)	Check availability of list and functionality of medical equipment and instrument, (check whether the list of necessary items is available, confirm if the items are physically available, check functionality of items). 3: Medical equipment and instrument can deliver 80% and above of the services required 2: Able to deliver 40-80% 1: Less than 40%	*- Lists (essential medical equipment and instrument)* *- Interview how to utilize the lists*	*Clinical Department (all)* *Other (tools and equipment for the department)*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
Area 7 Physical Assets								
1	Functional utilities are in place (water, electricity, sanitary ware/sewerage, fan/air conditioner, telephone/communication)	Observe functionality of utilities (water tap is functioning, A/C is working, toilets are clean and working, no leaking pipes, switch, tube lights/bulbs are working). 3: All are working, 2: More than half are working 1: Half or less than half are working	*- Water tap is functioning,* *- A/C is working, toilets are clean and working,* *- No leaking pipes,* *- Switch, tube lights/ bulbs are working.*	*All*				
2	Reliability and availability of alternatives of utilities are in place	Observe sufficiency of amount available according to the working process of the area (e.g. Sufficient light, water for hand wash or toilet use). Check reliability and availability of alternatives of utilities (e.g. water storage in case of emergency, alternative source of light in case of shortage of electricity e.g. torch, battery source. 3: All are available 2: More than half are available 1: Half or less than half are available	*- Water storage (check storage tanks) in case of emergency,* *- Alternative source of light in case of shortage of electricity* *- Torch, battery source*	*All*				
3	There are no defects of the Utilities	Check if there are defects in the utilities (e.g. leakage of drainage system, loose and hanging electrical wires, inappropriate placed ceiling fan). 3: All are no defect and functioning well 2: Some damages are appeared 1: half or more are damaged	*- Leakage of drainage system,* *- Loose and hanging electrical wires,* *- Inappropriate placed ceiling fan*	*All*				
4	Rooms provide conducive and safe environment for required work processes	Check availability of adequate physical environment (Check adequate space, light, good ventilation, offers privacy, cleanliness). 3: Functioning 80% and above 2: Functioning 40 - 80% 1: Functioning less than 40%	*Check adequate space, light, good ventilation, offers privacy, cleanliness*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
5	Emergency preparedness plan	Check implementation of emergency preparedness plan (emergency exit, functional fire extinguisher). 3: Meet requirements of the hospital 2: There is the plan but not meet requirements of the hospital 1: No plan	*Check emergency exit, functional fire extinguisher*	*All*				
6	Buildings are in good state of repair	Observe the status of the buildings including painting, walls, ceiling board, roof, windows, doors and check if the buildings are user friendly to physically impaired individuals. Are there efforts of improvisation where necessary? 3: All are in good state of repair 2: Half or more area are in good state of repair 1: Less than half area are in good state of repair	*Check painting, walls, ceiling board, roof, windows, doors*	*All*				
7	Equipment and furniture are in a good state of repair and function throughout the year	Check presence of inventory list of equipment (e.g. Fridge, cooker, weighing scale) and furniture. Observe functioning of equipment and furniture and whether placed in appropriate place. Observe sufficiency of equipment and furniture. 3: All are present according to working processes 2: Half or more number of equipment are present according to working processes 1: Less than half number of equipment are present according to working processes	- *Inventory list of equipment* - *Check the function of equipment*	*All*				
8	Periodical Preventive Maintenance	Check presence of PPM schedule, its adherence to, check list of equipment needing repair and equipment that are obsolete (not repairable) are stored in appropriate areas. 3: The PPM schedule is present and adhered to- Move to Commodities 2: The PPM schedule is present but maintenance activities are not followed 1: The PPM is not scheduled	- *PPM plan*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
Area 8 Hospital Environment								
1	Cleaning materials are stored properly according to the IPC standard	Check whether all cleaning materials and tools; mops, squeezers, blushes, buckets, and so on, are storage properly by following the national IPC standard. 3: All cleaning materials and tools are storage properly according to the IPC standard 2: Some of cleaning materials and tools are storage properly according to the IPC standard 1: All cleaning materials and tools are not storage properly according to the IPC standard	*- IPC guideline* *- Store of cleaning material* *- Interview how to store the cleaning materials*	*All*				
2	Notice board is well organized and information is updated regularly	3: Notice board is well organized with proper categorization information and updated regularly with removal instruction. 2: Notice board is organized but seen the mixture of information (Target of notices is not clear) 1: Notice board is not established	*- Check the condition of notice boards*	*All*				
3	Availability of proper facilities for health care workers	Check availability of proper facilities for health workers namely changing room, staff toilet and bathroom, nap room with equipment, room for break etc. 3: All areas have proper facilities 2: Few areas have proper facilities 1: Non-areas have proper facilities	*-Check the facilities*	*All*				
4	Implementation of S1 activities	Check whether S1 (Sort) activities are practiced in the section; all unnecessary items are identified and removed from the workplace. 3: All unnecessary items are removed 2: All unnecessary items are not managed properly and not removed 1: Unnecessary items are not identified	*- Check unmercenary items* *- Interview how to remove unnecessary items*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
5	Implementation of S2 activities	Whether all items are well arranged in consideration with efficient and effective workflow/process in each place 3: All items are properly arranged in consideration with efficient and effective workflow/process 2: Some of items are properly arranged in consideration with efficient and effective workflow/process 1: No items are arranged in consideration with efficient and effective workflow/process	*- Check the arrangement of items* *- Interview how to arrange the items*	*All*				
6	Implementation of S3 activities	Check whether cleaning is properly done or not Check storage of cleaning materials, cleaning schedule displayed, waste management, 3: Cleaning is done with proper materials, proper timing, proper waste segregation 2: Cleaning is done sometimes with proper materials, proper timing, proper waste segregation 1: Cleaning is not done properly with proper materials, proper timing, proper waste segregation	*- Check the cleaning condition* *- Check cleaning materials, cleaning schedule* *- Interview how to manage the waste*	*All*				
7	Availability of "Self-Discipline" to internal clients (staff)	Check whether the section/department has and display "Self-Discipline" (e.g. slogan, message, posters etc.) to increase awareness of staff on QI activities 3: The self-discipline is displayed 2: The self-discipline is developed but not displayed 1: The self-discipline is not developed	*- Poster of Self disciplines*	*All*				
8	Availability of "Self-Discipline" to external clients (Patients, Visitors, Students, etc.)	Check whether the section/department has and display "Self-Discipline" (e.g. slogan, message, posters etc.) to participate in part of QI activities 3: The self-discipline is displayed 2: The self-discipline is developed but not displayed 1: The self-discipline is not developed	*- Poster of Self disciplines*	*All*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
9	Implementation of self M&E activities to all QA/ QI activities at the section/ department level	Check whether WIT plans and periodically conduct the self M&E to maintain 5S activities, and provide technical inputs Check the evidences on the self M&E (e.g. the results of self M&E, meeting minutes, self M&E tool(s) etc.) 3: WIT plans and periodically conduct the self M&E 2: WIT plans the self M&E but does not conduct as planned 1: WIT does not plan the self M&E	*- M& E plan* *- Monitoring report* *- Interview how to monitor QA/QI activities*	*All*				
10	Knowledge and skills on KAIZEN implementation among staff	Check whether the health workers at the section/ department have enough knowledge and skills to practice KAIZEN activities through interviewing, checking the reports of KAIZEN 3: All health workers have the enough the knowledge and skills 2: Some of health workers have the enough the knowledge and skills 1: None of health workers has the enough knowledge and skills	*- Ask to all staff about KAIZEN activities*	*All*				
11	Waste bins are placed in waiting rooms, corridors and all patient areas.	3: All categories of waste bins are placed with proper colour coding and bin liners, and placed where visitors can access easily. 2: Some categories of waste bins are placed 1: Waste bins are not placed	*- Check categories of waste bins in waiting room and corridors*	*All* *Hospital environment*				
12	Waste dumping points are clearly established for non-infectious and infectious materials with proper colour code	3: Waste dumping points are established based on the categories of medical wastes with colour code and fenced 2: Waste dumping points are established 1: Waste dumping points are not established and no rules for dumping medical wastes	*- Check the condition of waste dumping points*	*All* *Hospital environment*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
13	Reporting mechanism on QA/QI activities from the section/department to QIT	Check whether WIT of the section/department reports the progress of QA/QI activities to QIT or not 3: WIT reported the progress of QA/QI activities of the section/department to QIT periodically 2: WIT reported the progress of QA/QI activities of the section/department to QIT irregularly 1: WIT does not report the progress of QA/QI activities of the section/department to QIT	*- Report to QIT*	*All (WIT)*				
14	Establishment of WIT	Check whether WIT is established and is active to practice QI activities at the section/department 3: WIT is established and is active to practice QI activities 2: WIT is established but not active to practice QI activities 1: WIT is not established	*- Minutes of Meeting* *- TOR of WIT* *- Member list of WIT*	*All (WIT)*				
15	Implementation of 5S activities	Check whether 5S activities are introduced and practice at the section/department 3: 5S activities are practiced 2: 5S activities are introduced to the hospital but not yet start to practice 5S 1: 5S activities are not yet introduced	*- Minutes of Meeting* *- Interview what kind of 5S activities are done*	*All (WIT)*				
16	Hospital official vehicles are working are well maintained	3: All hospital official vehicles are working and well maintained with evidences 2: 2/3 of hospital official vehicles are working but others are under repair 1: All hospital official vehicles are not working	*- Maintenance record* *- Check the condition of hospital official vehicles*	*Administration*				
17	Conference hall is well maintained for seminars and trainings	3: Conference hall is well maintained for seminars and trainings and generating incomes for the hospital 2: Conference hall is well maintained for seminars and training for internal use 1: Conference hall is not maintained and find lots of broken furniture and mal function facilities.	*- Check the condition of conference hall*	*Administration*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
18	Staff registry is well organized	3: Staff record is well organized with numbering or alphabetical coding 2: Staff record is organized but difficulty in retrieve staff record 1: Staff record is not organized and lots of missing files are reported	*- Staff record*	*Administration*				
19	Hospital billboard/sign board is well organized and information is updated regularly	3: Billboard/Sign board is well organized with proper categorization information and updated regularly. 2: Billboard/Sign board is organized but seen the improper information (Target of sign is not clear) 1: Billboard/Sign board is not well utilized and organized	*- Check the condition of Billboard/sign boards*	*Administration*				
20	Availability of standardized checklist to organize work environment	Check availability of standardized checklist to maintain well-organized work environment through implementation of S1 (Sort), S2 (Set), and S3 (Shine) activities. 3: The standardized checklist is developed and used 2: The standardized checklist is developed but not used 1: The standardized checklist is not developed	*- Standard checklist* *- Interview how often use the standard checklist*	*Administration (QIT)*				
21	Proper parking places for Vehicles, motorbikes and bicycles are allocated for visitors and staff as well as official vehicles	3: Parking place is established with safety regulations, speed limit and instructions 2: Parking place is established with proper zoning 1: Parking place is not established or established without zoning	*- Check the condition of parking place*	*Administration Hospital environment*				
22	Patient files are well organized	3: The file is well organized with numbering and possible to retrieve files in 30 seconds 2: The file is organized but difficulty in retrieve patient's file 1: The file is not organized and lots of missing files are reported	*- Check the condition of medical record in the record store?*	*Administration Clinical Department*				

SQ #	Indicators	Marking criteria	Means	Department / Unit	Weak 1	Fair 2	Well 3	*Comments*
23	Areas for providing medical care; admission areas, consultation room, patients' waiting room etc., are clean and maintained	3: Majority of the areas are clean, maintained and tidy 2: Few of the areas are clean, maintained and tidy 1: All areas are very dirty and not maintained	*- Check cleanness of admission areas, consultation room, patients' waiting room etc.*	*Clinical Department*				
24	Efficient patient flow is established in the department / Hospital	3: Majority of areas established efficient patient flow by providing clear instructions and proper information 2: Few of areas established efficient patient flow by providing clear instructions and proper information 1: All areas are not established efficient patient flow	*- Instruction to Patient* *- Ask patient flow*	*Clinical Department* *Hospital environment*				
25	Efficient flow of health workers by arrangement of items	Check whether all items namely medicines, equipment, medical supplies, medical machines and furniture are well arranged considering with efficient workflow 3: All items arranged properly 2: Few items arranged properly 1: Not arranged properly	*Check work flow and compare to position of each items.*	*Clinical Department* *Hospital environment*				
26	Hospital premises and corridor are well cleaned and maintained	3: Majority of Hospital premises and corridor are cleaned and tidy 2: RRHMT is started to improve cleanness and tidiness of Hospital premises and corridor 1: Hospital premises and corridor are very dirty and not maintained	*- Check cleanness of premises and corridor*	*Hospital environment*				
27	External facilities (canteen, kiosk etc.) are well cooperative to keep hospital premises clean	3: The premises around the external facilities are very clean and tidy 2: External facilities are understanding and trying make the premises clean and tidy 1: External facilities are making hospital premises dirty	*- Check cleanness of canteen, kiosk etc.*	*Hospital environment*				
28	Incinerator is working to dispose medical wastes	3: Incinerator is in place and working and well maintained with evidences 2: Incinerator is in place and working but not utilized well 1: Incinerator is in place but broken down	*- Check the condition of incinerator*	*Hospital environment (Waste Management)*				

Annex for Chapter 2-2: Reporting format of ISS

1. Hospital overview of the results of ISS

1.1. Strength

1.2. Weakness

2. Overview of the result of the monitoring

2.1. Hospital average score

Category	Rate (%)	(Graph: Average of Hospital Average)
Leadership and Governance		
Annual Hospital Activities		
Financial status		
Human resource for Health		
Commodities and medical supplies		
Services provision and quality		
Physical assets		
Hospital environment		
Average		

2.2. Score by Department

Department Area 1		Rate (%)								
		Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Average	
1	OPD									
2	Surgical Department									
3	Internal Medicine									
4	Paediatric									
5	Obstetric & Gynaecology									
6	Orthopaedic									
7	Psychiatric									
8	Pharmacy									
9	Radiology									
10	Laboratory& Mortuary									
11	Administration									
12	Kitchen									
13	Laundry									
14	HCWM/ Hospital Environment									
15	Dental									
16	NHIF									
17	Physiotherapy									

3. Way Forward

Areas to be improved	*How to improve the situation*

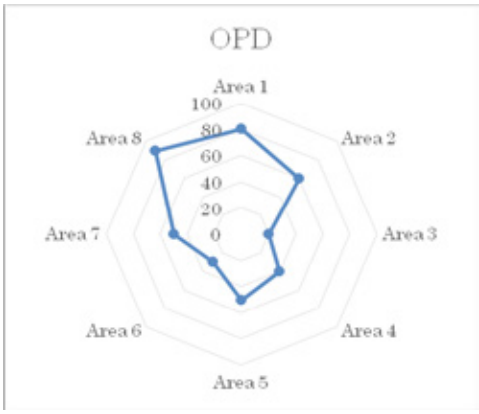
4. ISS Results of each department

Example: Name of Department: OPD

Rate (%)								
Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Average
80	60	20	40	50	30	50	90	52.5

Strength:

Weakness:



Name of Department: Surgical Department

Rate (%)								
Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Average

Strength:

Weakness:

Note: Develop all department respectively

(Rader Chart)

Annex for Chapter 2-3. List of required documents on ISS

In all department

1	Organogram of the department/unit	11	Duty Roaster of the department/unit
2	Meeting schedule and minutes of meeting in the department/unit	12	Standard Operation Procedures (SOPs)
3	Monthly minutes of financial report	13	Record of QA/QI activities
4	Machine and service comprehensive price list	14	Minutes of meeting and report to QIT (WIT)
5	Exemption guideline	15	Record of KAIZEN activities
6	List of activities implemented based on approved budget in the department/unit	16	OPRAS form Training plan, schedule and report of the department/unit
7	Financial report of the department/unit	17	Job allocation of the department/unit
8	Attendance register of the department/unit	18	Periodical Preventive Maintenance (PPM) plan
9	Emergency preparedness plan	19	Inventory list of equipment
10	IPC guideline	20	Safety check list

In clinical department

1	Drug control Sheet, ledger, dispensing book prescription register and prescriptions
2	Standard medicine list, tracer list, locally provided essential medicine/supplies list
3	List of essential medical equipment and instrument
4	Instruction to patient

In administration

1	Job description	5	Policy document	9	OPRAS form	13	Report of recognition event in QA activities
2	Succession planning	6	Hospital strategic plan	10	List of new staff oriented	14	Maintenance record of vehicle
3	Training plan	7	Hospital preparedness emergency plan	11	Minutes of CHOP meeting	15	5S standard checklist (QIT)
4	Promotion plan	8	Task description	12	Training schedule for QA (QIT)	16	M&E plan & monitoring report (QIT)

In NHIF Department

1	Financial report

Chapter 3: External Hospital Performance Assessment (EHPA)

Performance assessment of hospitals has been conducted for many years in Tanga, Mbeya, Lindi and Mtwara under the support of GIZ. External hospital assessment is also being conducted in some hospitals, health centres and dispensaries using tools that have been developed to meet specific objectives of the desired assessment example; Star Rating Assessment tool. The Ministry has decided to introduce the practice of External Hospital Performance Assessment (EHPA) to all RRHs with a view to establish comprehensive and continuous measurement process of RRH's performance. Thus, this chapter will provide guidance on how to conduct effective EHPA.

3.1. Concepts of External Hospital Performance Assessment

3.1.1. Definitions of terms

In the guideline, external hospital performance assessment is defined as "A system for measuring the readiness of service provision of the hospital through the gap between ideal situation and status based on the standard operation procedures (SOPs)". However, definition of hospital performance assessment in general is interpreted in several terms; this includes:

Inspection:

Minimal requirements of the hospital functions measured based on the regulations or legislations. Generally, regulation or legislation body under the government (national or municipal) carries out the inspection for the hospitals.

Satisfaction Survey:

The gap between satisfaction and expectation of the patients are measured by questionnaire survey. The survey tools need to be standardized for reliable study and bench-marking among the hospitals.

Third Party Assessment:

Authorized or licensed third party, assesses the performance of the organization based on the standard operations. ISO is one of the major systems of third party assessment.

Accreditation:

Independent agency(s) authorizes the status of the hospital based on its criteria. The hospitals need an incentive to apply the accreditation.

3.1.2. Hospital Performance Assessment (HPA) in Tanzania

3.1.2.1. National level

The MoHCDGEC has defined a framework for HSSP IV Performance Assessment and Follow-Up, which includes a set of nationally agreed upon HSSP IV indicators covering all areas of population health, service delivery outputs, support systems performance as well as governance and financial areas. Furthermore, the M&E framework incorporates the KPIs as formulated for the BRN[4] National Key Result Area for Health. Finally, the M&E framework contains a number of more qualitative indicators which monitor implementation activities of HSSP IV strategies.

M&E will take place with regular intervals, with an emphasis on measuring annual health sector performance, drawing from the three indicator sets. The Joint Annual Health Sector Review (JAHSR) will have the necessary inputs for strategic decisions for improvement of performance of the health and social welfare sector.

4 The health and social welfare sector programme of Big Results Now (BRN) 2015 - 2018, the national programme for accelerating development, is fully incorporated in HSSP IV.

3.1.2.2. Regional level

RHMTs conduct Regional Management Supportive Supervision (RMSS) to Council Health Management Team (CHMT); referred as "RMSS-C" in their respective regions quarterly. The major aim of RMSS is to support CHMTs to identify their strengths and weaknesses in terms of management matters and help them to find solutions to problems they face.

3.1.2.3. Council level

On the council level, several types of performance assessment are carried out in selected regions and councils. Star Rating system is utilized for measuring the achievement of the National Key Result Area for Health.

3.2. Existing HPA tools in Tanzania

3.2.1. Indicators-Based Assessment Approach and Tools by TGPSH

The Tanzanian German Programme to Support Health (TGPSH) contributed by Deutsche Gesellsehaft Fur Internationale Zusammenarbeit (GIZ) supports Quality Management activities in 12 hospitals (Government and Faith-Based owned hospitals) in Lindi, Mbeya, Mtwara and Tanga regions. To enable objective monitoring of QI-improvements a contracted agency (Evaplan) set to establish an indicator-based approach. The assessment tools are 5 multi-perspective (Patient and Staff Questionnaires, Self-assessment Questionnaire, Facility Interview Guide, Facilitator Checklist) and 300 indicators (66 structures, 130 processes, 104 outcomes). The collected data is filled on Excel based software. Through the assessment, information on hospital quality performance can be gained with transparency for all staff. The information will be a base for developing prioritized QI plans for target hospital.

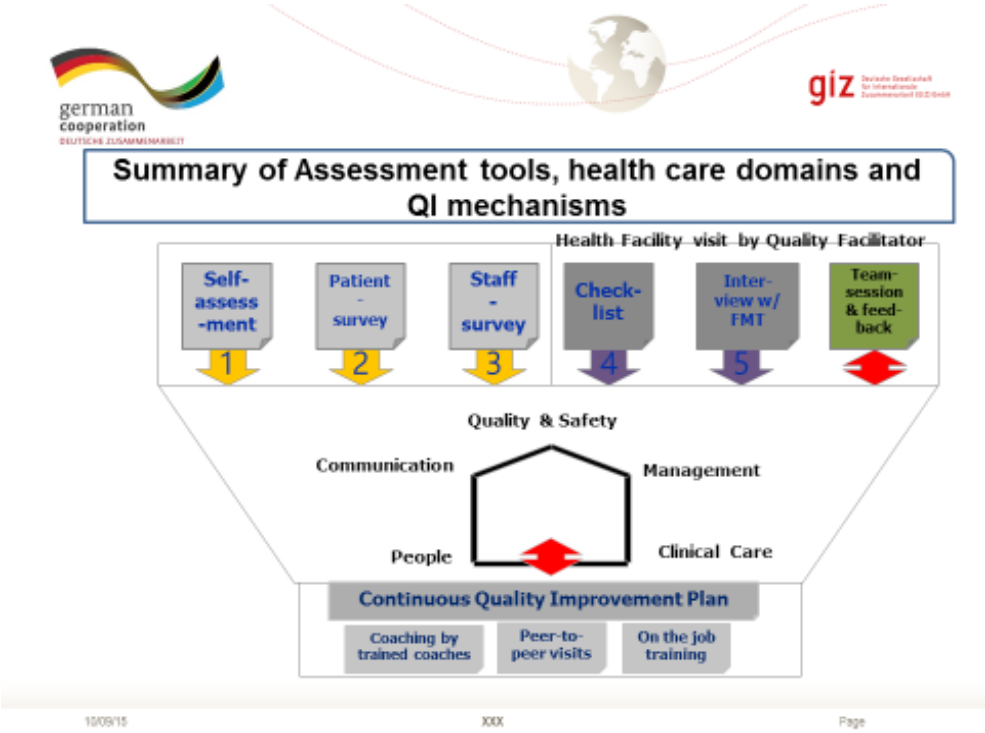


Figure 3-1: Brief concept of QI mechanism on TGPSH

3.2.2. Stepwise Certification and Accreditation

SafeCare initiative which was established in 2010 by three organizations (Pharm-access International (PAI), The Council for Health Service Accreditation of Southern (CoHSASA) and JCI), introduced Stepwise Certification towards Accreditation (SWCA) in resource constrained countries. SWCA was introduced in Tanzania), targeting primary health facilities using a set of basic healthcare standards (SafeCare standard) which recognizes five levels (Level 1-5).

The ministry will further introduce Stepwise Certification Towards Accreditation (SWCA) system based on

objective independent assessments of quality of service provision using an agreed set of valid qualities of health care indicators. The ministry has started with the introduction of a Star Rating mechanism for all primary health care facilities. The view of the ministry is to have 80% of health facilities with 3 Star Rating or higher and good performance in patient satisfaction.

3.2.3. Quality Improvement and Infection Prevention and Control (QI & IPC)

This program started in 2004 implemented by the MoHCDGEC in collaboration with JHPIEGO-ACCESS targeting five-consultant hospitals, three regional hospitals, three district hospitals and one designated district hospital (DDH). Main activities on the program are training of health workers, developing IEC materials, conducting supportive supervision and providing safety boxes.

3.2.4. Star Rating

The Star Rating provide a national overview of the status of health facilities and guide further priority setting for identifying bottlenecks for health facility quality improvements to be addressed. Under-rated health facilities get support from the Councils to bring them up to standard, e.g. refurbishment of infrastructure, recruitment of additional staff, training or supportive supervision. Criteria for facility to obtain 5 Star Level See Table 3-2.

Table 3-2: Criteria for 5 Star Rating of Primary Health Facilities

Assessment Area	Characteristics of Facility at 5 Star level
Facility Management & Governance	■ Strong governance structure ■ Implements best practices for managing resources appropriate skilled staffing complement as per staffing establishment ■ Excellent working conditions/environment for staff including housing and appropriate incentives
Use of Facility Data	■ Accurate and comprehensive data ■ Staff who can perform data analysis ■ Staff who uses the data for service improvement
Performance Assessment	■ Functioning performance system for staff ■ Staff who have met over 80% of their performance targets
Social Accountability	■ Strong functioning HFGC/Council Health Service Board that is responsive to the needs of the community ■ Facilitates an inclusive planning process for HF plans and by fully executing these plans
Organisation of Services	■ Well-organised setup for service delivery · Well-organised and efficient process for maintaining and accessing records
Emergency Cases	■ Fully trained staff and a strong functioning system to triage, refer if needed ■ Successfully handle emergency cases as per the norms for the facility type
Health Infrastructure & Infection Prevention Control (IPC)	■ Consistently available power, running water, and functional equipment ■ Have infection, prevention and control and waste management systems that are implemented according to national guidelines.
Clinical Services	■ RMNCAH, FP, outpatient and inpatient, and specialist services are fully provided according to standard protocols ■ Minimal patient waiting times

Assessment Area	Characteristics of Facility at 5 Star level
Clinical Support Services	■ Continuous availability of medicines that are appropriately stored and rationally used ■ Availability of quality diagnostic services according to the standards of the facility type ■ For HC and Hospitals, they must have fully functioning operating theatre with measures in place to prevent sepsis

In addition to the ones mentioned above, there are other HPA such as International Organization for Standardization ISO 9001, ISO 15189, and NHIF accreditation for registration of NHIF members in the country.

3.3. Adoption of a tool from existing HPA tools

In the context of the health sector in Tanzania, external hospital performance assessment shall be;

- Measurable for achievement of objectives on Health Sector Strategic Plan IV
- Applicable into current health system in Tanzania
- Sustainable for periodical assessment and reporting and
- Affordable under the budget constraint

As mentioned above, there are several different HPA tools introduced and operating in Tanzanian health sector without proper coordination. Developing completely a new assessment tool could make the situation worse and confuse hospital management team more. Therefore, it was agreed among stakeholders that EHPA tools for RRHs should be developed based on the existing assessment tools. Hence, the EHPA has been developed based on "Star rating mechanism for council hospitals." Necessary indicators for assessment of RRH are drawn from Regional Management Supportive Supervision for Hospital (RMSS-H), ISS and 5S-KAIZEN-TQM approach (see Figure 3-2).

Comparing to RMSS-H, EHPA does not only assess the management area but also the service provision areas. Therefore, EHPA for RRH is comprehensive measurement process of RRH's performance.

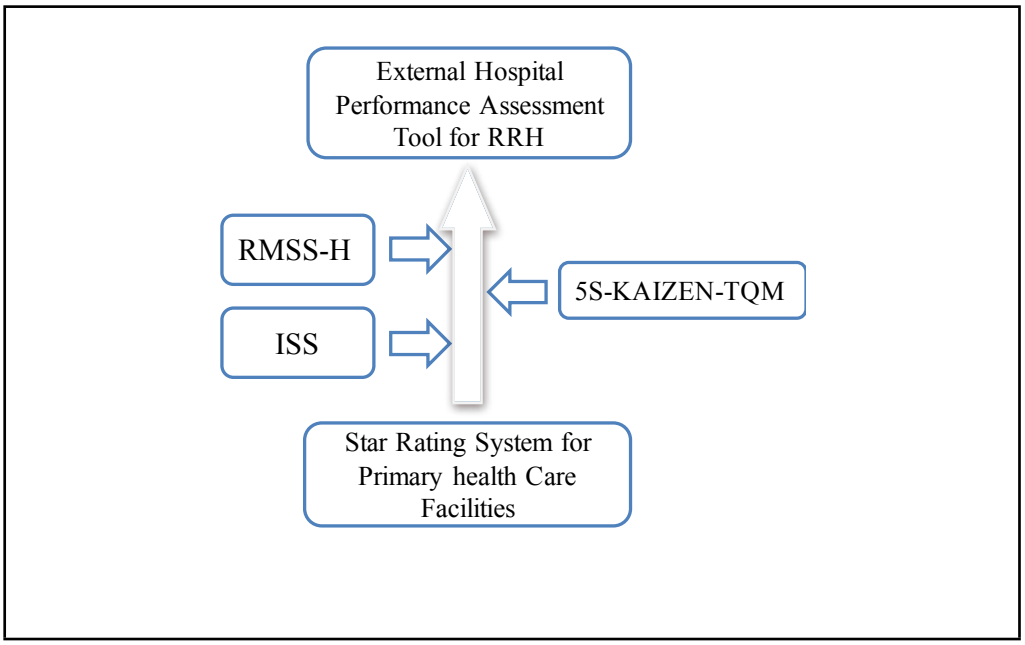


Figure 3-2: Image of development process for external HPA tools

3.4. EHPA Tools for RRHs

EHPA tools consist of EHPA checklist, Annexes, and Feedback and Report formats. For the actual tools and checklist for EHPA, please see the Annex for Chapter 3-1, 3-2, and 3-3.

3.4.1. EHPA Checklist

(1) Assessment Areas

The EHPA checklist has total of twelve (12) areas with 109 indicators and some of them have sub-questions to identify the status by multi-dimensions.

Table 3-3: Areas, Sub-Areas and number of indicators of EHPA

Area	Sub-Area	No. of Indicator
1. Legality		2
2. Hospital Management	Facility Management	7
	Facility Autonomy and Fiscal Decentralization	6
	Working Conditions	4
3. Use of Hospital Data for Planning and Service Improvement	Function of HMIS	2
	Information Use and Dissemination	1
	Medical records	2
4. Staff Performance Assessment	Staff Performance Appraisal System	5
5. Organization of Service	Service Provider Charter	5
	Client Flow	2
	Health Promotion Services	2
6. Handling Emergencies and Referral	Appropriate Handling of Emergencies	6
	Referral Mechanism	1
	Emergency Preparedness and Response Services	1
7. Client Focus	Client Service Charter	3
	Client Satisfaction	1
8. Social Accountability	Social Accountability Assessment	2
	Functional Hospital Advisory Boards	2
9. Hospital Infrastructure	Planned Preventive Maintenance (PPM)	2
	Buildings	8
	Utilities	2
	Equipment and Furniture	2
10. IPC, Safety Measures and Risk Management	Infection Prevention and Control (IPC)	7
	Healthcare Waste Management	4
	Fire Safety	1
11. Clinical service	Outpatient services	2
	RMNCH-Services	1
	Inpatient Services	4
12. Clinical Support Service	Pharmaceutical Services	7
	Laboratory	7
	Operation Theatre	4
	Radiology and Imaging	2
	Mortuary Services	1
	Food Services	1

(2) Question / Verification Method

"Question" on the checklist means the indicators to measure the status of target areas and sub-areas.

"Verification Method" on the checklist means how to find the answer of the question. Some questions need several checkpoints to identify the answer.

(3) Response

"Response" on the checklist means types of pre-set answers for the questions. Responses are described as number 1 to 3 and the number is filled in "Score" on the checklist as the answer. Additionally, some comments regarding answer needs to be filled in "Comments" on the checklist if necessary.

(4) Means of Verification

"Means of Verification" on the checklist means how to collect information answering the question.

(5) Department /Unit

"Department / Unit" on the checklist means the department where the question needs to be asked. There are questions which are specific to selected departments though some questions need to be asked several departments/ units.

3.4.2. Annexes of EHPA checklist

"Annexes" of EHPA contain necessary information for verification. There are 14 documents listed as below:

No.	Documents	No	Documents
1	Personnel List	8	Tracer Medicines
2	Revenue Collection Checklist	9	Checklist for Tracer Medicine in selected Department
3	Checklist of HMIS registers and related tools	10	Emergency Equipment List on OT
4	Emergency medicine checklist /	11	Client Exit Interview
5	Emergency equipment checklist	12	SOPs for Dispensing
6	Standard Equipment and Furniture List	13	Protocols for OT (Refer WHO 2007), Best Practice Protocols Clinical Procedures Safety
7	Recommend antiseptic and disinfectant	14	Essential Post-mortem/autopsy Equipment

3.4.3. Brief Feedback Reporting format of EHPA

Standardized feedback reporting format was developed for reporting of the results of EHPA. Assessment team is requested to use the format when feedback session is held at the target hospital. Please see attached for Chapter 3-2.

3.4.4. Comprehensive EHPA report format

Standardized reporting format was developed for writing the comprehensive EHPA report, which needs to be shared with RRHMT and submitted to MoHCDGEC and copied to RMO. Using the standardized reporting format will make the record keeping and compilation of the results easier. Therefore, it is strongly advised to use the format. Please see attached Annex for Chapter 3-2.

3.5. How to conduct EHPA at RRH

3.5.1. Frequency and duration of EHPA

EHPA should be conducted at least once a year by MoHCDGEC and may incorporate RHMT after receiving an annual report from RRH. Ideally, The EHPA shall be conducted between August and September of every year. Timing of EHPA and RMSS-H are linked with ISS, which is conducted quarterly by RRHMT. Please see figure 3-3: "Frequency of ISS and EHPA, and linkage with other key activities" below.

After receiving the CHOP annual report, MoHCDGEC will analyse the current issues in the target RRH and conduct EHPA based on the issues identified in the analysis of that report. EHPA will be conducted for a duration of not exceeding four (4) days; the fourth day is for analysis, report writing and feedback to RRHMT. The assessment team must share EHPA results and agree the way forwards.

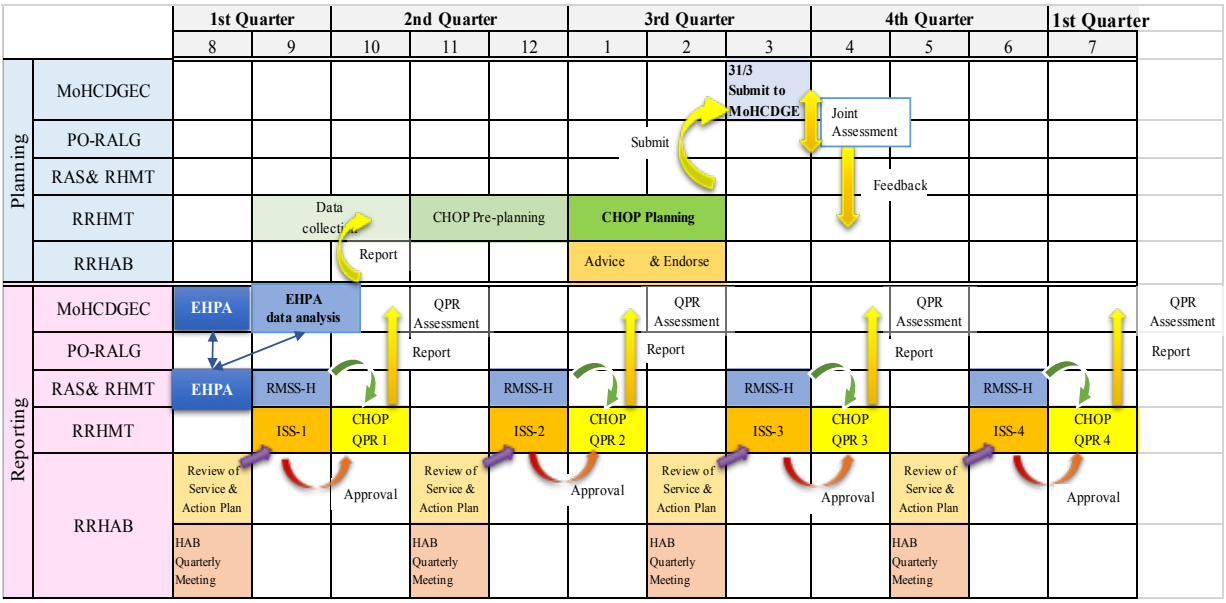


Figure 3-3: Frequency of ISS and EHPA, and linkage with other key activities

Step	Action	Responsible	Deadline
Step 1	Develop schedule of EHPA	MoHCDGEC/RHMT	Two weeks before execution of EHPA
Step 2	Compose Assessment team	MoHCDGEC/RHMT	One week before execution of EHPA
Step 3	Orientation of Assessment team & Review of previous RMSS-H / EHPA	MoHCDGEC/RHMT	Before execution of EHPA
Step 4	Preparation for EHPA	MoHCDGEC/RHMT	Before execution of EHPA
Step 5	Conduct EHPA	Assessment Teams	Within 3 days 1-1.5 hours for each target depart-ment
	5-1 Courtesy to Medical Officer in charge or Director		
	5-2 Receive implementation report of previous ISS & EHPA		
	5-3 Hospital round		
	5-4 Actual assessment		
	5-5 Immediate feedback at department		
Step 6	Analysis and compilation of EHPA results	Assessment Team	3rd and 4th day of EHPA

Step	Action	Responsible	Deadline
Step 7	Brief Feedback to RRHMT	Assessment Team	4th day of EHPA
Step 8	Submit report to CRHS	Assessment team	By 7 days after execution of EHPA
Step 9	Compile and Analyse EHPA Reports from Assessment Teams	Coordinator, Regional Health Services (CRHS)	By 14 days after received from Assessment Teams
Step 10	Submit comprehensive report to DCS/ DPP-MoHCDGEC	Coordinator, Regional Health Services (CRHS)	By 3 days after Compilation
Step 11	Share comprehensive report to PO-RALG and RHMTs, DPG-Health	Coordinator, Regional Health Services (CRHS)	After the report has been signed by DCS/DPP

3.5.2. Schedule of EHPA

MoHCDGEC and relevant authority will develop a schedule for EHPA, which shows date of assessment, and what consists the assessment. It is highly recommended that the schedule is to be available in writing to RRHMT. The schedule should take into consideration the following:

In preparation of the schedule the organisers/Assessment Teams should remember to avoid conducting EHPA when the hospital is congested: for instance; in epidemic outbreak, seasonal infection diseases, national ceremony in the hospital, etc. The Assessment Team Leader should ensure a set of soft/hard copy of a set of Annexes of EHPA checklist to be filled by RRHMT is sent to the RRH in advance. Detail of Annex of EHPA checklist is in Annex for Chapter 3-3. It is noted that the first EHPA should be conducted by the 3rd week of August and the second EHPA should be conducted by the 1st week of February.

3.5.3. Composition of assessment team

The assessment team will be formed by maximum of six (6) members. The composition of the assessment team will include the members with different competencies from MoHCDGEC/RHMT. Dividing assessment team into sub-groups is necessary for effective assessment within limited timeline.

3.5.4. Orientation of Assessment Team on EHPA

It is important that assessment team should be conversant with the processes of conducting EHPA, knowledgeable on EHPA tools, marking methods and criteria. Coordinator, Regional Health Services (CRHS) should organize pre-assessment orientation sessions on how to use the tools, existing and available technical guidelines, standards, as well as how to analyse results and to keep record. The pre-assessment orientation is of paramount importance for the team members to understand the recommendations from the previous EHPA to monitor agreed interventions. For important guidelines, manuals and documents for ISS and EHPA refer Annex Chapter 2-3, and Chapter 3-3.

Additionally, assessment team should understand EHPA is not audit; it is for improvement of RRH's performance. Therefore, assessment team needs to understand interventions that would be taken to improve identified gaps especially using approaches such as 5S-KAIZEN-TQM which is used for problem solving and improvement of the situation. They also need to comprehend the linkage between the 5S-KAIZEN-TQM approach and the whole idea of developing evidence-based CHOP.

RRHMT develops evidence based Comprehensive Hospital Operation Plan (CHOP) annually and implement the plan to operate the hospital efficiently. The progress of implementing the plan is then; monitored by RRHMT quarterly through ISS. Any weakness or problem in operating the hospital, identified during ISS must be resolved by RRHMT through 5S-KAIZEN-TQM approach using, QIT and WITs. In this regard, 5S-KAIZEN activities at RRH are also monitored through EHPA Tool and Consultation Visit Tool in which progress implementation gaps identified by all these tools i.e. ISS; CV and EHPA become inputs to the development of next CHOP. As reference, tools for Consultation Visit on 5S-KAIZEN-TQM are attached in the Annex.

3.5.5. Composition of EHPA assessment team and competencies of assessors

As mentioned in the above, EHPA should be conducted by MoHCDGEC officials and may incorporate RHMT members. One EHPA assessment team can be formulated with three (3) to four (4) people selected from MoHCDGEC and RHMT. If it is necessary to complete EHPA within short period of time, it is necessary to formulate four (4) to six (6) assessment teams, and conduct EHPA in parallel.

Assessors should have the following competencies:

- Good listening skills,
- Ability to probe, analyse and formulate solutions.
- Ability to inspire others, establish and maintain trust, and promote teamwork spirit
- Adequate knowledge of what is being supervised.
- Openness to new ideas
- Ability to conduct coaching and learn from others.
- Ability to conduct supportive supervision and monitoring
- Ability to provide and receive feedbacks after each visit
- Ability to write and share assessment reports timely
- Knowledge of ISS and 5S-KAIZEN-TQM

3.5.6. Preparation in the target hospital

What is the important thing implementing EHPA is to properly assess the situation of service provision and the status of facilities in RRHs. If RRHMT is trying to hide the facts and trying to show off the good things only during the EHPA, it is very difficult to assess the facts and may not be able to provide proper advices to improve the current situation. Therefore, RRHMT should understand the actual meaning of the EHPA and accept the visit of assessment team to complete the assessment smoothly. Thus, it is important to clearly explain the objectives of EHPA and request the RRHMT to actively cooperate with the EHPA assessment team.

3.5.7. Implementation process

In actual EHPA implementation, assessors should do the follow:

- Arrive at the facility on agreed time;
- Pay courtesy call to the Medical Officer in-charge (introduce yourself and your team, objectives, sites to be visited, agree on how the assessment will proceed and de-briefing date);
- Review previous RMSS-H/EHPA reports, assess level of implementation of agreed tasks and provide feedback in relation to the previous tasks if any;
- At beginning of the assessment, it is recommended that the team goes around the hospital with the hospital secretary as an EHPA introductory round visit and to observe current situation of RRH. Thereafter, the team agrees on how to go around target departments if necessary.
- Visit the required department/units/sections on the checklists (conduct observations, interviews and documents review).
- Exit interviews for the patient and observations of staff attitudes are conducted at selected departments.
- Establish if there is any alarming problem that needs immediate attention and agree on corrective measures to be taken

- Provide immediate feedback to the departments/units/sections. Team should give positive comments first on current situation, and then points out where need to be improved

Please note that use of open ended questions is recommended and the team must check after the assessment whether all information required and in checklist are filled and scored.

3.5.8. Pictorial record keeping

Pictures are one of the very strong evidences for describing the situation of RRHs. Therefore, the assessment team members are required to have pictorial record keeping skills.

Pictures of the following areas should be taken and recorded during EHPA:

- Entrance of RRH with signboard
- Appearance of the hospital (OPD, administration block, wards)
- Filings and office arrangement in administration block
- Wards and nurse station
- CSSD
- Operating theatre
- Laboratory
- Mortuary
- Waiting area of OPD
- Pharmacy store and Pharmacy dispensing area
- Passage way to Wards with signboard
- Practices of waste segregation, IPC
- General store
- Incinerator

Pictures of the other areas can be taken according to the needs. If disorganized areas or wrong practices are found in the facilities during the EHPA, please keep the pictorial records and information of each picture (where and when the pictures were taken)

Examples of pictures

Appearance of the hospital

Medical record

OPD waiting areas

Good waste segregation following IPC guideline

3.5.9. Analysis and Compilation of EHPA Results

The EHPA results must be analysed, compiled and reported back to the hospital on an excel format developed for easy calculation for the score of each area. For smooth compilation and analysis of the EHPA results the assessment team should follow the procedure below:

(1) After assessment, assessors of each group should meet and agree on the scores as per their areas of assessment,

(2) Scores and comments from each group are then compiled and filled in one hard copy of assessment tool,

(3) Fill score of each question on the excel format,

(4) Write the reason why the score is low or high on the comments column,

(5) Check the average score of each area and sub-area,

(6) Discuss why the average is low or high and identify what crosscutting causes are in each area and sub-area,

(7) Compile crosscutting causes when the causes are affected to the other areas or sub-areas, as core or root causes, Collect and file all the pictures (best practice & areas for improvement) in one folder and

(8) Report the results of the analysis/discussion for feedback presentation with pictorial support evidences of best practice & areas for improvement.

Note: The team needs to identify what are root causes and/or crosscutting issues on the current worse situation, and/or what is core strength on the current good situation. All RRHMT members should keep records of the analysed data for future monitoring of implementation process. Hospital secretary shall take responsibility of keeping the records of EHPA. Minimum time frame of keeping EHPA results is 5 years.

3.5.10. Feedback to RRHMT / RMO / MoHCDGEC

The results of the EHPA need to be shared with the RRHMT of respective target hospitals directly and immediately through feedback session at the hospital and provide copy of written report of EHPA to RMO. Thereafter, the EHPA report is submitted to MoHCDGEC for planning and policy decisions making as in Table 3.4.

It is noted that the EHPA report is one of the important evidences for guaranteed well performing RRH management through PDCA cycle. Thus, the Ministry would clamour for RRHMT to utilize the EHPA report for CHOP evidence-based planning. MoHCDGEC should utilize the EHPA report in assessing CHOP plans to know if the planning did reflect the gaps identified in the EHPA report.

(1) Feedback to RRHMT

The assessment team will provide immediate feedback in the feedback session. During immediate feedback (reporting format is in Annex 3-4), the assessment team should:

- Acknowledge support of RRHMT and staff in conducting EHPA,
- Appraise for general strengths,

- Highlight on areas of improvements, comments on problem solving and stimulate RRHMT to think on how to solve problems on their own, and
- Ask for feedback/comments from RRHMT and the staff on the assessment process and tools.

(2) Feedback to RMO office

After EHPA, the chairperson of the assessment team should share the EHPA results with the Regional Medical Officer (RMO). The written comprehensive EHPA report will be finalized and submitted by the assessment team to Coordinator, Regional Health Services (CRHS) within 7 days after EHPA and thereafter follow the steps as detailed in Table 3.4. The report should include following contents. A detail content of the comprehensive report format is in Table 3-5.

- Title
- Table of contents
- Acknowledgement
- Acronyms
- Executive summary
- Introduction
- Objectives
- Findings and analysis
- Conclusions and recommendations
- Appendices
- References

(3) Distribution of copy of the comprehensive report to RRHMT

CRHS will distribute the comprehensive report to RRHMT and RRHMT should share the EHPA report with HAB and hospital staff.

(4) Report to MoHCDGEC

The comprehensive report shall be submitted to MoHCDGEC following details on Table 3.4. The reporting mechanism of EHPA, however, needs to be aligned with CHOP and CHOP QPR assessment mechanism.

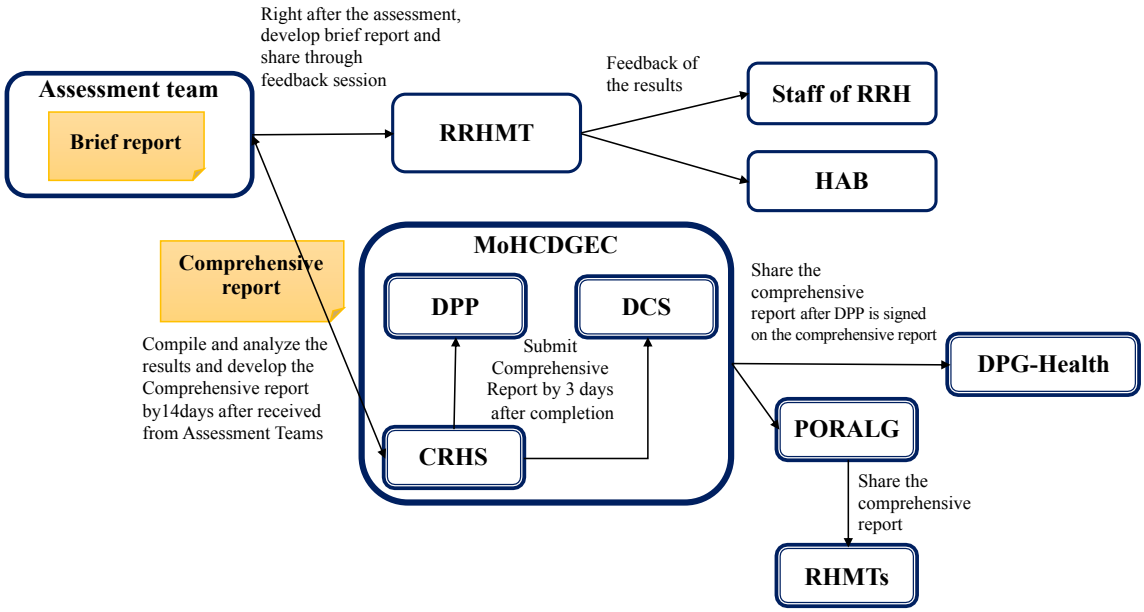


Figure 3-3: Reporting mechanism of EHPA

Comprehensive report of EHAP needs to be utilized for both RRH and national level. In terms supporting RRH, RRHMT has a responsibility to properly manage RRH, focusing on addressing the findings of the results of EHPA. MoHCDGEC is responsible to set direction of national health policies referring to the results of EHPA as rationale for the policies centre of concentration.

3.5.11. EHPA Reporting

After completion of data analysis, it is necessary to develop the comprehensive report. The format of the EHPA comprehensive report is as follows;

Table 3-5: Contents of EHPA report

Items	Description
Acknowledgement	Word of appreciation to individuals and stakeholders who participated and supported the assessment.
Acronyms	Short forms (abbreviations) of words written in full
Executive Summary	This section presents to the reader in summary form the most essential information of what are in the whole report. It is supposed to not exceed two pages. It includes the objectives, findings, conclusion and recommendation. In the report, the summary comes first, but it is written after all the proceeding sections of the report have been written.
Introduction	States the purpose of the assessment, places visited and key people met. A brief description of the methodologies applied in conducting the assessment should be included in this section.
Objectives	It states broad and specific objectives of conducting the HPA.
Findings	The findings from RRH should be reported hospital by hospital. Findings from each area need to be summarised under the categories of "Strengths", "Weaknesses" and "Constraints or challenges" that were observed during the assessment. Emphasis can be made on those key issues (weaknesses) found. Average EHPA score and score area by area need to be reported with radar chart and tables. Additionally, pictures of good and improper practices need to be placed in this part. See Annex C

Items	Description
Recommendations	This part includes suggested actions or activities to be taken or implemented by RRHMT to improve weaknesses that were observed with resultant improvement in quality of service.
Conclusion	This part winds up the report and reinforces the main messages of the whole report. It draws inferences from the entire process about what have been found and the impact of the findings.
Appendices	The information that supports the findings, analysis and validates conclusion will be placed in the appendices. Example of information that could be included in the appendices are figures, graphs, tables, pictures, maps, charts, letters, questionnaire, other tools and names, designation of people met as well as their contact addresses.

Annex for Chapter 3-1: EHPA Checklist

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
Area 1: Legality							
1.1	Valid Licence	Does the health facility have a valid license for provision of services? *Check for presence of:* *-Registration and up to date license for Private HFs as per Private Health Advisory Board Regulations* *-OR MSIMBO (HMIS) number for Public Facilities OR HFR*	Y. Registration and up to date license for private facilities from Private Health Advisory Board OR Msimbo number for public facilities OR HFR N. No license OR license not up to date for Private HFs as per Private Health Advisory Board OR no Msimbo number for public facilities OR HFR		*Administration*		
1.2	Service Agreement	Does the facility have a service agreement with the government? *If applicable, ask the facility manager to show you the service agreement.*	Y. Valid service agreement in place N. No service agreement or not valid NA. For public facilities		*Administration*		
Area 2: Hospital Management							
2.1	**Facility Management**						
2.1.1	Organization structure	Is there an organization structures for the hospital and department that are openly displayed? *Check Hospital and department organogram – administration block and in at least three departments*	3: Observed correct organizational structures documented and displayed in administration block and in at least three departments 2: Organization structures documented but outdated or not displayed 1. No organization structure documented		*Administration* *OPD* *Internal Medicine Ward* *Pharmacy*		
2.1.2	Human Resource available in the Hospital	How many staff are available at this hospital based on staffing level? *Ask the hospital manager for the number of staff available compared with establishment (Annex 1)*	3: More than 75% of staff is available 2: 40-75% of staff is available 1: Less than 40% of staff is available	*Annex.1 (Personnel list)*	*Administration (HRH)*		
2.1.3	Human Resource availability at duty station	How many of each staff cadre have reported at the duty station on daily basis? *Check attendance register/ biometric register for the number of staff by cadre that have reported for duty in the past month for each cadre.*	3: More than 80% of staff by cadre is reported 2: 40-80% of staff by cadre is reported 1: Less than 40% of staff by cadre is reported	*Annex.1 (Personnel list)* *Attendance /Biometric registers*	*Administration (HRH)*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
2.1.4	HRHIS Analysis and Use	1. Have you regularly updated Human Resource for Health Information System (HRHIS)? -*Verify in the human resource database*	3: Regularly updated Human Resource for Health Information System (HRHIS) is available 2: There is HRHIS but not updated regularly 1: No HRHIS	*Confirm with the responsible person*	*Administration (HRH)*		
		2. Do you conduct analysis of Human Resource in your hospital, through utilization of (HRHIS)? *Verify the HRHIS sheet and analysis part in CHOP / hospital plan* *-Ask their opinion on HR Situations*	3: Having overall analysis and taking actions 2: Having the analysis but no action 1: No overall analysis	*HRHIS database, (human resource database), RRHMT minutes (health management minutes)*	*Administration (HRH)*		
		3. Do you share analysis results amongst all RRHMT/HMT? And How? *Verify in monthly RRHMT/HMT minutes (hospital management meetings minutes)*	3: Shared among all members with meeting minutes 2: Shared but no meeting minutes 1: Not regularly shared	*Check dates of updating, RRHMT minutes (health management minutes)*	*Administration (HRH)*		
2.1.5	Human Resource Management	1. Is staff attendance and absenteeism monitored? *Check if Human Resource has done analysis of staff attendance in the last two months.*	3: Completely analysis of staff attendance (during last 2 months) 2: Some analysis of staff attendance observed 1: No analysis		*Administration*		
		2. Does the hospital have updated health worker skill profile for each cadre that includes on job training undergone by each cadre? (align with HRHIS human resource database) *Check training report and verify in HRHIS (human resource database)* *Check training report on 5S -KAIZEN-TQM, IPC*	3: Completely updated (during last 6months) skill profile observed 2: Some updated skill profile observed 1: No updated skill profile available	Updated health worker skill profile	*Administration*		
		3. Has there been a training needs assessment? *Check for a report on training needs.* *Check if the department has prepared its own training needs assessment.*	3: Presence of training needs assessment report in all target department 2: Presence of training needs assessment report in few target department 1: No / outdated training needs assessment report observed	Training needs assessment report	*Administration* *Laboratory* *Pharmacy* *Operation Theatre*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		4. Is there on-job training schedule in department/ward? *- Ask HCWs* *- Check if there is on the job training e.g. weekly presentations, weekly clinical meetings, weekly mentorship and coaching.* *- Check for training schedule on the necessary working skills i.e (5S -KAIZEN and IPC)*	3: Presence of training schedule and implementation report in department/ ward at least three departments 2: Less than three departments 1: No training schedule	• Implementation report • Mention departments	*Administration* *Laboratory* *Surgical Ward* *Labour Ward*		
		5. Does hospital/ department have succession plan? *Verify the availability of report for at least three departments) Mention departments*	3: Documented Succession plans are available in all target department 2: Less than three departments 1: No documented succession plans	documented Succession plan	*Administration* *Laboratory* *Pharmacy* *Operation Theatre*		
		6. Does the hospital have a promotion plan for the staff? *Verify the availability of promotion plan*	3: Promotion plan is available 2: Promotion plan is considered but not documented 1: No staff promotion plan	Promotion plan	*Administration*		
		7. Is there a system for orientation of staff? *Interview two most recently employed staff for the past one year or verify report (signed orientation checklist) of orientation of those staff.* *Interview how to conduct orientation to new staff*	3: Orientation reports (signed orientation checklist) available for all staff interviewed 2: One or more staff member not oriented, or not verifiable 1: No staff member not oriented, or not verifiable	newly employed staff orientation	*Administration* *(Selected two new employees)*		
		8. Is there a plan for induction of the newly employed staff in the Hospital? *Check if there is an induction plan for newly employed staff*	3: Induction plan in place and implemented 1: No induction plan no report	Induction plan and report	*Administration* *(Selected two new employees)*		
2.1.6	Health Facility Management Team Functional	1. Has the Hospital Management Team been formally appointed with terms of reference? *Check for appointment letters and terms of reference*	3. Appointment letters seen with terms of reference 2. Appointment letters seen but no terms of reference 1. Appointment letters not seen, or no terms of reference	ToR and Appointment letter	*Administration*		
		2. Does the management Team meet on regular schedule? *Check if schedule of meetings is available and posted*	3. Schedule of meetings available 1. No schedule of meetings, or no Management Team	Meeting schedule	*Administration*		

Responses	Means of Verification	Departments/Units	Score	Comments
e available for Man- n for past 3 months and report is sent to RHMT e available for less than or reports not sent to , or no report available	Monthly Minute of Meeting	*Administration*		
tion are available entation (no ToR, no	Disciplinary committee, ToR, meeting minutes	*Administration*		
proper responsiveness / n RRHMT/ HMT and response to lower level a vay (from RRHMT/ *HMT* vel) ion	Section/ departmental minutes	*Administration* *OPD* *Internal Medicine Ward* *Pharmacy*		
f implementation of mentorship is available plan but no report	Coaching and Mentoring report QPR	*Administration*		
established and function- tings in last 3 months and rting structure) lished but not fully func- an 3 meetings in the last 3 or no clear) ablished	List of QIT members, Appointment letters with ToRs, schedule of meetings, Minutes of QIT meetings, Minutes of HMT and QIT meetings	*Administration*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		2. Does the QIT meet on regular schedules? *Check if schedule of meetings is available*	3. Schedule of meetings available 1. No schedule of meetings, or no QIT	Schedule of Meetings	*Administration*		
		3. Are QIT meetings conducted at least quarterly and recorded? *Check if there are minutes available for the past three consecutive months.*	3. Minutes are available for QIT meeting in previous quarter 1. No minutes available, or no QIT	Schedule of Meetings Minute of Meeting	*Administration*		
		4. Does the Hospital conduct and report internal(self) assessment on quality of service at least quarterly? *Check for a report of Quality Assessment, gaps identified and related QI plans, internal self-assessment of 5S-KAIZEN implementation from the previous quarter conducted by the facility staff alone or in collaboration with RHMT members*	3. Report of internal quality assessment available, gaps identified, and quality improvement plans specified for the last quarter. 2. Report available but lacking clear gap identification and/or improvement plan 1. there was no internal assessment/no report available	Reports of Quality Assessments	*Administration*		
		5. Have there been any documented quality improvement activities at the hospital in the past quarter (conducted by the QIT or WIT or in collaboration with RRHMT/ HMT members)? *Check for documented or verifiable of QI activity and/or photographic evidences*	3: Report of internal quality assessment available, gaps identified, and quality improvement plans and implementation report specified for the last quarter. 2: Report available but lacking clear gap identification and/or improvement plan or no implementation report 1: There was no internal assessment/no report available	Report of internal quality assessment, implementation report, photographs	*Administration*		
		6. Is there a functional WIT in each department? *Check availability of the following:* *i) List of WIT members,* *ii) WIT meeting minutes,* *iii) Action plan for WIT (reflecting all quality improvement activities including feedback provided by external supervisors),* *iv) Implementation report of previous plan/ intervention%,* *v) Departmental/sectional training /orientation,* *vi) Photographic evidences, etc.*	3: If all five department have functional WITs (all criteria available) 2: If three have functional WITs or all five have WITs but not all are fully functional 1: No WITs or less than three are functional	List of WIT members, minutes of meetings, action plan, implementation plan, photographs	*Administration,* *Laundry* *Pharmacy* *Kitchen* *Labour Ward* *OPD*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		7. Is awarding or recognition ceremony /events towards QA/QI activities available? *Check availability of documents/minutes from the past year*	3: Documents/ minutes are available for the wpast year 2: There is a document but no minute 1: No documents/ minutes or outdated reports	Documents of Recognition (Recognition letters, Certificates) Minutes of QIT meeting	*Administration*		
2.2	**Facility Autonomy and Fiscal Decentralisation**						
2.2.1	Facility Planning and Budgeting	1. Do you have up to date 5-year strategic Plan which is in line with HSSP-IV and submitted to RAS/AAS (Hospital Advisory Board for private) for approval? *Check existing copy of hospital's 5-year strategic plan*	3: 5-year strategic Plan available and in line with HSSP IV and submitted 2: 5-year strategic Plan available but not in line with HSSP IV/ not submitted 1: No plan	5-year strategic plan available,	*Administration*		
		2. Have you prepared the quarterly financial and technical reports, and share with RHMT and/ or HAB? *Verify availability of last 4 quarterly reports*	3: Reports for the last 4 quarters are available and submitted in time to HAB and RHMT 2: Reports are available, but not submitted to HAB and/ or RHMT/ less than 4 reports available 1: No reports	Quarterly financial and technical reports with submission letter	*Administration*		
		3. Did the hospital receive a written feedback on submitted quarterly financial and technical reports, from RHMT and/ or HAB? *Check for documentation*	3: Documented feedback from RHMT and/ or HAB seen from last 4 quarter reports 2: less than last 4 quarter reports 1: No documented feedback	Feedback report of Quarterly financial and technical reports	*Administration*		
		4. Are the financial accounts audited (internal and external audit)? *Verify availability of internal and external auditing reports for the past year*	3: Both internal and external audit reports for the past year in place 2. Internal or external audit report for the past year 1: No internal and external audit reports for the past year	Financial Audit Report	*Administration (Finance)*		
		5. Does the hospital have outstanding external/ internal audit query *Verify timely responses made to audit queries*	3: No audit query or Yes and timely responses within 21 days 2: Response made but Not timely 1: No response	Copy of audit query response	*Administration (Finance)*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
2.2.2	Appropriate Expenditure on Medicines and Health Products	1. How much money is spent for purchasing medicines and health products? *Check if at least 67% of expenditure is on medicines and health products from statements of bank account and records for a six-month period.*	3: 67% or more of total expenditure was for purchase of medicines and health products 1: Less than 67% of total expenditure on medicines and health products NA: If private hospital	Financial reports	*Administration (Finance)*		
		2. Is there any mechanism to control medicines stock level by using 5S-KAIZEN activities to prevent over / under stocking?	3. Regularly updated inventory management records, application of visual Control and monthly physical count are present 1. None of the above		*Administration (Finance)*		
		3. Is there any MSD and other suppliers verified outstanding debt for the past FY? *Check reconciliation reports of hospital account with MSD and other suppliers*	3. No debt 1. Outstanding debt present NA: If private hospital	Reconciliation reports	*Administration (Finance)*		
2.2.3	CHOP Preparation	1. Do you have necessary documents for effective planning? *Check availability of:* *i) CHOP guideline for public/ Health sector Public Private Partnerships (PPP) policy guidelines for private* *ii) Policy documents (such as current Health Policy , Cost sharing guideline),* *iii) 5 year Hospital Strategic plan* *iv) HSSP-IV* *v) Previous CHOP, Budget Instructions for public*	3: All documents are in place 2: A few documents is in place 1: All document are missing	CHOP guideline, policy documents etc.	*Administration*		
		2. Did you prepare Comprehensive Hospital Operation Plan (CHOP) or Hospital Plan (for private) for past FY based on the data collected and shared with HAB and submitted on time to RAS/AAS? (for private to share with HAB)	3: CHOP/ Hospital Plan is available for past year, it is consistent with DHIS2, HRHIS etc., shared with HAB and submitted on time to RAS/AAS 2: CHOP/Hospital Plan is available for	CHOP/ Hospital plan	*Administration*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		Check: *i) The analysis of DHIS2* *ii) HRHIS sheets* *iii) Findings from EHPA, RMSS, ISS and financial reports if it corresponds with the information in CHOP/ Hospital Plan* *Check the submission date to HAB and RAS/ AAS (for private to share with HAB)*	past year, but not shared with HAB or submitted on time to RAS/AAS/ or inconsistent with DHIS2, HRHIS, financial reports 1: No CHOP/ Hospital Plan				
		3. Are there any activities in your CHOP/ Hospital Plan to improve hospital service quality? *Verify the various activities in the CHOP/ Hospital Plan and other reports; e.g.* *i) QIT meetings,* *ii) QI Trainings,* *iii) QIT budget line,* *iv) Procurement of medicines and* *v) Supplies etc.*	3: Five QI activities 2: One to four QI activities 1: None	CHOP document/ Hospital Plan	*Administration*		
2.2.4	CHOP Implementation	1. Is implementation of planned activities monitored? *Check for Evidence of Quarterly Progress Report (QPRs) for the last year, regular RRHMT/ HMT and departmental meeting minutes*	3: Implementation of planned activities are monitored (QPRs) and minutes are available 2: Monitored but no minute 1: No current QPRs, no current departmental meeting minutes for monitoring implementation of CHOP/Hospital Plan	QPRs, minutes of meetings (department and RRHMT/ HMT)	*Administration*		
		2. Are activities implemented based on approved budget and reporting format based on departments/sections? *Check if implemented activities correspond to approved department budget Reporting format based on departments/sections*	3: At least 80% of the planned activities were implemented according to approved budget 2: 50% to less than 80% of the planned activities were implemented according to approved budget 1: Less than 50% of the planned activities were implemented according to budget.	CHOP/ Hospital Plan Implementation reports	*Administration*		
2.2.5	Revenue Collection	1. Have you made any efforts to improve hospital revenue collections and income generation? *Check for: Annex.2 (Revenue collection checklist)*	3: More than three actions are in place to improve hospital revenue collections and /income generation 2: Less than three actions 1: No action	Annex.2 (Revenue collection checklist),	*Administration (Finance)*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		2. What is the trend of revenue collection compared to the target set regarding cost sharing, NHIF and others (out of pocket, private insurance) in your hospital in the last quarter? *Check the financial reports with respect to trend of revenue collection compared to targets set*	3: More than 80% of the target collection for the last quarter was achieved 2: 50% - 80% of the target collection for the last quarter was achieved. 1: Less than 50% of the target collection was achieved or no target set	Financial reports	*Administration (Finance)*		
		3. Have you discussed monthly financial report in your department /section in the last month? *Check the minutes of last month departmental meeting to verify if financial report was discussed.*	3: Minutes of all 3 departments show financial report was discussed 2. Minutes of 2 departments show that financial report was discussed 1: Only 1 or No discussion of financial report	Meeting schedule Minutes of Meeting	*Administration* *Laboratory* *Pharmacy*		
		4. Are there means to reduce wastage of resources? *Check department/ward for correct use of:* *1) Logbooks* *2) Dispensing books, bin cards, FEFO,* *3) Movement books (time, HR management)* *4) Financial control etc.*	3: At least 4 resource wastage mechanisms are in place and correctly filled 2: Less than 4 resource wastage mechanism are in place 1: No mechanism in place	1) Logbooks 2) Dispensing books, bin cards, FEFO, 3) Movement books 4) Financial control etc.	*Administration* *Pharmacy* *Laboratory*		
2.2.6	Supportive Supervision	1. Has internal supportive supervisions (ISS) been conducted to all departments and wards in the hospital in the previous quarter? *Verify reports of ISS implementation and feedback to 3 departments in the last quarter*	3: Reports for ISS implementation and feedback are available in 3 departments and wards. 2: Reports for ISS implementation and feedback are available in 2 departments and wards. 1: Reports for ISS implementation and feedback are available for only one department or no report	ISS reports	*Administration* *OPD* *Paediatric Ward* *Laundry*		
		2. Have you conducted clinical SS to district hospitals in your region in the last quarter? *Verify the reports of the clinical SSs to district hospitals in the region in the last quarter*	3: Reports for clinical SS implementation and feedback are available in all councils 2: Reports for clinical SS implementation and feedback are not available for all councils 1: No clinical SS	Clinical SS reports Feedback report to RAS Feedback report to RMO	*Administration*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
2.3	**Working Conditions**						
2.3.1	Housing for staff	1.Are housing/housing allowance provided for eligible staff? *Ask the facility in charge/ Hospital Secretary*	3. Housing/ housing allowance are provided to all eligible staff. 2. At least half of the eligible staff are provided with housing/housing allowance. 1. Housing/ housing allowances not provided by the facility.	Interview Pay slip	*Administration*		
2.3.2	On call amenities	Are there suitable rooms for on-call staff within the hospital? *Verify presence of at least 2 furnished rooms (male and female) in the RR hospital for on call staff. Furnished means at least bed(s) and chair (s).*	3: 2 Furnished rooms for on-call staff 2: Rooms available but not suitable or not furnished/ only one room available 1: No on-call room or amenities	Physical Check	*Administration* *Staff on-call room*		
2.3.3	Extra-duty and on call allowances budgeted	Is there provision for extra-duty and on-call allowances in current financial year? *Check approved hospital plan and budget for those allowances*	3: Current budget includes extra duty and on call allowances. 2: There is plan but not disbursed 1: Budget does not include those allowances	CHOP	*Administration*		
2.3.4	Retention Mechanisms	Is there Human Resource retention program available and functioning? (e.g. Housing, Performance based rewards, continuous education, so on) *Verify the available retention programs / mechanism in CHOP and/ or other documents/ reports.*	3: Program & Document available 2: Program but no Document 1: No Program & document	Human Resource retention program and documents	*Administration*		
Area 3: Use of Hospital Data for Planning and Service Improvement							
3.1	**Function of HMIS**						
3.1.1	Staff trained on HMIS	Is any of the hospital staff trained on the current HMIS/ Electronic Medical Record (EMR)? *Ask Hospital manager if there are staff who were trained and check training record*	3: Records show at least two staff members trained on HMIS manual/ EMR 2: Only one staff trained 1: No staff trained on HMIS manual/ EMR	training reports	*Administration*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
3.1.2	HMIS tools in use and filled correctly	1. Is the HMIS Summary Book and EMR in use and is correctly filled for the previous month? (for services offered at the hospital) *Verify that the HMIS Summary Book and/ or EMR is accessible and updated with the last month's submission to MoHCDGEC through DHIS2*	3: HMIS summary book and EMR is updated 2: One of them is updated 1: HIMS summary book and EMR not updated	HMIS summary book, EMR	*Administration*		
		2. Are the HMIS registers and related tools available and in use on the day? *Refer checklist of HMIS tools for specified services. Tick box for registers, tally sheet and summary forms, as verified available and in use.*	3: All 15 HMIS registers and related tools available and in use 2: 10 to 14 HMIS registers available and in use 1: Less than 10 HMIS registers available and in use available	Annex.3 (HMIS checklist)	*Administration* *HMIS office*		
		3. Are the HMIS registers and related tools correctly filled? *Check for completeness of recording and correct filling of the tools (sample at least 6 registers)*	3: Information in sampled registers is complete 2: Some samples are not complete 1: Information in all sampled registers incomplete	Annex.3 (HMIS checklist)	*Administration* *HMIS office*		
		4. Are the submitted HMIS data valid and reliable? *Cross-check for data accuracy, consistency and correct compilation by comparing source data from OPD, maternal, neonatal and more indicators when need arise (register, tally sheets and summary form.*	3: Data in OPD, maternal, neonatal registers correspond to tally sheets and summary forms 2: Some of them corresponds 1: Data in OPD, maternal, neonatal registers do not correspond to tally sheets and summary forms completely	Data in OPD, maternal, neonatal registers Tally sheets, summary book	*Administration* *HMIS office*		
3.2	**Information Use and Dissemination**						
3.2.1	Data interpreted and used at the facility	1. Have you conducted any operational research and /or survey or used available data to improve the hospital operational performance in the last two quarters? *1) Check document on how did hospital/dept. use analyzed data on improving health service delivery / performance or trend. e.g. in Hospital score card and other indicators* *2) Check for displayed data in two departments*	3: Hospital has a document and /or display based on analyzed data 2: The hospital has interpreted but not displayed information 1: No evidence of data interpretation and use	Hospital Analysis data	*Administration* *Laboratory* *Labour Ward*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		2. Is there a facility profile report for the last year based on HMIS data? *Check if there is a facility profile report*	3. The facility uses HMIS data to prepare facility report 2. Report is present but lacks the necessary information 1. The facility does not use the HMIS data to prepare a facility profile report	Facility profile report	*Administration*		
3.3	**Medical records**						
3.3.1	Recordings and Retrieval of medical records	1. Is there a system for managing patient records (Either Paper based/Electronic)? *For paper based: Check if there is stationery and a standard format for records, and a filing system for easy retrieval (5S concept application) and storage located near reception area* *For Electronic: IT personnel, functional computer, existence of intranet, backup system, reliable electricity backup, etc.*	3: Patient has at least a card for file number, files are well arranged and easy to retrieve. For electronic all mentioned items available 2: Some of them is not well arranged 1: No system for easy retrieval of files.	Medical Record (10 sample) Utilization of 5S tools e.g. labeling, numbering, colour coding etc.	*Administration (Medical Record)*		
		Is there any action taken to shorten retrieval time of medical records? *Check existing actions for improvement of retrieval time*	3 If KAIZEN approach is applied and evidence of shortening the retrieval time is observed, 2.KAIZEN approach is ongoing but no evidence of improvement, 1. No action taken	KAIZEN records	*Administration (Medical Record)*		
		2. Are medical records properly completed for all patients seen at the hospital? *Check 10 patient records for history, physical examination, diagnosis, treatment and follow up if applicable; select from both outpatients and inpatients seen in the previous week.*	3: All records examined were properly completed 2: At least 3 -9 of the examined records were properly completed 1: Less than 3 records are properly completed	Medical Record (10 sample)	*Administration (Medical Record)*		
3.3.2	Confidentiality assured for patients records	Are patient records handled in a way that assures confidentiality? *For Paper based: Check patient records to see if names and private or confidential details are only visible to healthcare workers, and there is a secure room or lockable storage area for patient records and use of 5S tools and visual control to restrict entry of unauthorised personnel* *For Electronic: Passwords, etc.*	3: Records are handled confidentially and stored in a secure and lockable cabinet or shelf unit or only responsible personnel can access patient record if electronic system is in use. 2: some records are not handled confidentially 1: Confidentiality is not assured completely.	Medical Record (Condition of storage)	*Administration (Medical Record)*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
Area 4: Staff Performance Assessment							
4.1	**Staff performance appraisal system**						
4.1.1	Staff performance method in place	Is OPRAS/ other method in place to assess staff performance? *Verify the method in use in the current financial year and up to date for all staff. (ask the personnel officer, sample randomly ten files)*	3: Up to date, filled OPRAS for the current financial year for all staff 1: No OPRAS/ not up to date for the current financial year for all staff	Staff records/ file	*Administration(HRH)*		
4.1.2	Staff performance targets agreed	Are performance targets agreed by staff and supervisor? Do these targets include quality improvement initiatives? *Interview 5 staff from various departments to find out if they are aware of targets.*	3: All Selected staff have agreed performance targets set in OPRAS form/ alternative form and include quality improvement initiative 2: Some staff have agreed targets 1: All Staff have no agreed performance targets	Interview Staff records/ file	*Administration (HRH)* *OPD* *Internal Medicine Ward* *Labour Ward*		
4.1.3	Effective review of individual performance	1. Is OPRAS form/ or alternative form filled for half year performance review? *Check staff records/file (ask the personnel officer, sample randomly ten files)*	3: Mid-year review done for all staff 2: Mid-year review done for some staff 1: Mid-year review not done for all staff	Staff records/ file	*Administration(HRH)*		
		2. Are there rewards and consequences based on OPRAS performance/ alternative method? *Interview 2 staff per department/section*	3: Rewards and consequences are provided at all selected staff 2: Rewards and consequences are provided at some selected staff 1: No rewards or consequences provided	Interview	*Administration (HRH)* *OPD* *Internal Medicine Ward* *Labour Ward*		
4.1.4	Staff satisfaction with performance review system	Are staff satisfied with the performance review system (OPRAS)? *Interview 3 staff from 3 department each*	3. More than half were satisfied 1. Half or less were satisfied	Interview 3 staff from 3 departments	*OPD* *Internal Medicine Ward* *Labour Ward*		
4.1.5	Individual job and task descriptions	Are individual job and task descriptions available for all staff and signed? *Check staff records/files* *Sample of two staff from three department each*	3: Signed individual job and task descriptions available for six examined staff 2: Individual job and task descriptions available but not signed, or availed to staff / signed job descriptions not available for all staff 1: No individual job or task descriptions available	Staff records/ file	*Administration* *Laundry* *Mortuary*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
Area 5: Organisation Of Services							
5.1	**Service Provider Charter**						
5.1.1	Facility name, working hours and on call and duty rosters	1. Is sign board well organized with updated information? *Observe the availability of sign board*	3: Sign board is well organized with updated information. 2: Sign board is organized but seen the improper information (Target of sign is not clear) 1: No Sign board	Sign board	*Hospital Environment*		
		2. Is the on–call roster accessible to clients, with contact numbers? *Check access at entrance or registration area and if contact numbers are displayed to the public*	3: Clients can access the on-call roster with contact numbers at all selected department 2: Clients can access the on-call roster with contact numbers at some selected department 1: Clients cannot access the on-call roster or contact numbers not availed	Notice board	*Laboratory* *X-ray* *Pharmacy* *Labour Ward*		
		3. Is notice board well organized and information is updated regularly with removal instruction? *Observe if notice board is well organized and information is updated regularly with removal instruction.*	3: Notice board is well organized with proper categorization information and updated regularly with removal instruction. 2: Notice board is organized but seen the mixture of information (Target of notices is not clear) 1: Notice board is not used	Notice board	*OPD* *Laboratory* *Pharmacy*		
		4. Is the duty roster in your department/wards displayed and adhered to? *Check attendance register*	3: Attendance register corresponds to duty roster 2: Attendance register corresponds to duty roster partially 1: Attendance register does not correlate with duty roster	Attendance register	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
5.1.2	Service Charter for core healthcare services	1. Is there a charter indicating the package of services provided and standards of care for core services? *Ask to see the charter, check the quoted standards of care e.g. maximum waiting time, use of gloves for clinical procedures, rapid tests, injections, dressing, etc.*	3. Documented charter on waiting time before a client is seen in core services 1. No documented charter	Documented charter	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		2. Are healthcare providers aware of the charter? *Ask one healthcare in three selected departments to quote the charter on the service package and any related standards of care e.g.. In 1 above*	3. Healthcare providers can quote the charter on waiting times before a client is seen 1. Not able to quote the charter on waiting time	Interview	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
5.1.3	Services, insurance benefits and charges are displayed	1. Is a list of services with prices displayed at reception and payment counter / departments? *Check availability of list of services and price at reception and payment counter/ department*	3: List of services with prices displayed at reception and payment counter/department 2: Available but not displayed at reception and payment counter 1: No list of services with prices	Notice board	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
5.1.4	Schedule for Special Clinics	2. Is a list of medicines with prices available? *Check if list of medicine price is available.*	3: List of medicines with prices displayed at reception and payment counter 2: Available but not displayed at reception and payment counter 1: No list of medicine with prices	Notice board	*OPD* *Labour Ward* *Pharmacy*		
		3. Is a list of all exempted services, groups and diseases available and displayed? *i) Check availability of list of exempted services, groups and diseases* *ii) Verify against the local national policy on exemptions.*	3: List of exempted services, groups and diseases are displayed at reception and payment counter 2: Available but not displayed at reception and payment counter 1: No list of exempted service, groups and diseases NA: For private hospitals NB: not FBO with service agreement	Notice board	*OPD* *Labour Ward* *Pharmacy*		
		4. Are staff aware of exemption policy and its beneficiaries? *Ask At least 2 staff if they are aware of National cost sharing (should be in annex guidelines and its beneficiaries? Mention at least 5 beneficiaries.* *Check if the exemption guideline is in place*	3: At least 5 beneficiaries are mentioned by all interviewed staff and guideline is in place in all examined departments 2: Some beneficiaries are mentioned and guideline not in place in all examined departments 1: Not mentioned and guideline not in place NA: For private hospitals NB: not FBO with service agreement	Guidelines Enquiring Interview	*OPD*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		Is there a clearly displayed specialized clinic (e.g. Diabetes, ENT, OT, BGY, etc.) schedule showing dates, day and time? *Check if specialized clinic schedule is displayed*	3: There is a specialized clinic schedule with day and time displayed 2: There is schedule with missing some important information (day and time) 1: There is no specialized clinic schedule	Schedule on Notice board	*OPD*		
5.1.5	Social Accountability	Is information displayed on availability of the following resources? (Key information on available resource is displayed) a) Summary of Plans and Budget b) Allocation of medicines & Supplies *Check that the information can be viewed by the public*	3: Complete Information about all 3 items displayed 2: Information less than three items displayed/ incomplete information 1: No information displayed about those items *NA: if private hospital*	Notice board	*Administration* *OPD*		
5.2	**Client Flow**						
5.2.1	Optimal Client flow and Self-discipline Instructions	1. Are the service provision points arranged to allow optimal flow and waiting area for clients within the available space and building plan? *Observe the route and path of a client (e.g. outpatient) from entry to exit, accompanied by a hospital staff member, noting if there any known bottlenecks.*	3: Service provision points are arranged to ensure smooth flow of clients and adequate waiting space completely 2: Some of them are well arranged. 1: Service provision points and waiting are not well arranged	Observation	*OPD*		
		2. Are there labels in Kiswahili for service points and directions to guide clients to the next service provision point? *Check if the directions are well posted and the labels for spaces, rooms and service points are in Kiswahili.*	3: Labels are available in Kiswahili for direction and rooms according to services 2: Labels are available but not in Kiswahili, or not sufficient for all service points 1: There are no labels available	Observation	*OPD*		
		3. Is "Self-Discipline Instructions" for external and internal clients available? (Patients, Visitors, Students, HCWs etc.) *Check whether the section /department has displayed "Self-Discipline instructions" for external and internal clients (e.g. visiting hours, no smoking, quiet please, waste disposal etc.) in Kiswahili.*	3: The self-discipline instructions are displayed 2: The self-discipline instructions are developed but not displayed 1: The self-discipline instructions are not developed	The self-discipline instructions e.g. visiting hours, no smoking, quiet please, waste disposal, packing of vehicles etc. (in Kiswahili)	*Administration,* *Kitchen* *Laboratory* *Surgical Ward*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
5.2.2	Client waiting time monitored	Does the hospital monitor waiting time before a client is seen by a healthcare provider in outpatient services? i) *Check records to verify that a sample of client visits were monitored within the last month.* *(ii) Check if there is any action to reduce the client waiting time*	3: Client waiting time monitored within the last month 2: Time monitored but no action taken 1: No record of monitoring within the last month	Client waiting time monitoring record	*Administration*		
5.3	**Health Promotion Services**						
5.3.1	Facility based health education plan in place	Does the hospital plan and implement health education activities at the OPD? *i) Verify schedule, arrangements, where, how, who, and to whom the training are offered,* *ii) Verify if IEC material are available (TV, DVD, CDs, etc.)* *iii) Check report/documentation of health education activities implemented in the last quarter*	3: Health education plan, IEC material and Implementation report are available 2: there is a plan but not implemented based on the plan 1: No health education plan	Schedule and report	*Administration*		
5.3.2	Outreach health promotion services are scheduled	Are outreach services provided according to the schedule? *Check if there is a schedule for outreach health services* *Ask for a report/documentation on outreach services provided in the last quarter*	3: Schedule is present and Records of implementation according to schedule available 2: Schedule is present but no report of implementation 1: No schedule *NA: If private hospital*	Schedule of Outreach services Record of Outreach services	*Administration*		
Area 6: Handling Of Emergencies And Referrals							
6.1	**Appropriate Handling of Emergencies**						
6.1.1	Emergency unit/dept. is available and functional	Is there an emergency unit/department for emergency health services? *1Check if there is an emergency unit/department for emergency health services*	3: Hospital has an emergency department for emergence health services 1: Hospital has no dedicated area room for emergence services	Observation	*Emergency*		
6.1.2	Guidelines and SOPs for Emergencies are available	Are there readily accessible guidelines and SOPs and in use for handling emergencies? *Check that a reference copy of current guidelines example of Medical, Surgical, CEmONC, Integrated Management of Childhood Illness (IMCI) are available in the consultation room, or IMCI posters or job aides for danger signs identification.*	3: The required guidelines and SOPs are available and adhered to 2: Not all are available 1: None are available	Observation Simulation Interview	*OPD* *Emergency*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
6.1.3	Triaging system in place	Does the hospital have a triaging system in place? *Check if there is a triage area at the OPD, trained triage nurse, triaging plan, Emergency Triage Assessment and Treatment (ETAT) SOPs or equivalent are available in the hospital. Verify if these are in place.*	3: Triaging system in place 2: Triage is done but no trained triage nurse and no SOPs were found 1: No have a triaging system (more than 3 items missing)	Observation	*OPD*		
6.1.4	Healthcare Workers are Trained to handle Emergencies	1. Does the facility have any healthcare worker trained on managing medical and surgical emergencies? *Interview facility manager*	3. Facility manager confirms that healthcare workers have been trained and reports are available 1. No healthcare worker has been trained	Interview	*Administration*		
		2. Does the facility have any healthcare worker trained on managing maternal, neonatal and under 5 emergencies? *Interview facility manager*	3. Facility manager confirms that healthcare workers have been trained and reports are available 1. No healthcare worker has been trained	Interview	*Administration*		
6.1.5	Medicines for Emergencies are available	Does the hospital keep medicines for emergencies readily accessible and usable? *Verify ready access to medicines for emergencies on Annex.4-1. Check that they are in date and usable (within expiry date). Tick each item seen and usable.*	3: All items are available and usable 2: Fifteen items are available and usable 1: Less than fifteen items are available and usable	Annex.4-1 (Emergency medicine checklist)	*Emergency*		
6.1.6	Equipment for Emergencies care is available	1. Does the hospital keep equipment for emergencies readily accessible and usable? *Verify the presence of 13 items of equipment on Annex.4-2. Check that they are in working order. Tick each item seen and working.* *Check for expire date*	3: All 13 items are available and usable 2: Nine items are available and usable 1: Less than nine items are available and usable	Annex.4-2 (Emergency equipment checklist)	*Emergency*		
		2. Are there stretchers and wheelchairs ready accessible and usable in emergency care? *Verify that they are functioning properly.*	3. At least 5 stretchers and 3 wheelchairs are available 2. Less than 5 stretchers and 3 wheelchairs are available 1. Stretchers and wheelchairs are either unavailable or not functioning		*Emergency*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
6.2	**Referral Mechanism**						
6.2.1	Transport arrangement for prompt referral	1. Is there functioning referral system that is known to all staff? *i) Verify the document describing procedures of referral system (including referral laboratory system and prompt transfer is possible.)* *ii) Verify that ambulance is available and functioning* *iii) Interview 5 health care providers at 5 department* *iv) Medical & surgical ward to verify if staff are aware of the emergency transport arrangements and procedures* *v) Check the presence of hospital mobile phone or landline/functional radio call*	3: Documents available, staff are aware of the procedure, ambulance is working, and mobile/landline phone is available in all selected departments 2: Some departments have 1: No document in all departments	Procedures of referral system Interview	*OPD* *Paediatric Ward* *Labour Ward* *Internal Medicine Ward* *Surgical Ward*		
		2. Has hospital / department have a recording mechanism of referred patients (In/Out)? *Verify feedback records of patients returned from the upper level /send back to lower level*	3: Recording mechanism available in three departments 2; some departments have 1: No system in three departments	Record of referred patients	*OPD* *Surgical Ward* *Emergency*		
6.3	**Emergency Preparedness and Response Services**						
6.3.1	Emergency Preparedness and Response	1. Is there a functional emergency preparedness and disaster responsiveness team? *Check availability of the list and their contact, minutes of regular meeting*	3: The team is available and functioning 2: Team available but not functional 1: No team	Observation	*Administration*		
		2. Does the hospital have SOPs for emergence preparedness and disaster responsiveness? *Check the presence and accessibility of SOPs for emergence preparedness and disaster responsiveness*	3: SOPs available completely 2: Some SOPs available 1: No SOPs	SOPs	*Administration Emergence*		
		3. Are training and simulation on emergence preparedness conducted regularly? *Check availability of training report of the last year*	3: Both training and Simulation are conducted regularly 2: No training or simulation 1: All are not conducted	Simulation and training reports	*Administration*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		4. Are emergency preparedness equipment and identified assembly point available and functioning? (e.g. emergency exit, siren/alarm, functional fire extinguisher, assembly point) *Check the availability of equipment and its functions*	3: There is functioning of emergency preparedness equipment and identified assembly point 2: At least 1 item is missing 1: No equipment or assembly point	Observation	*Administration*		
Area 7: Client Focus							
7.1	**Client Service Charter**						
7.1.1	Client service charter displayed	1. Is the client service charter available at this hospital? *Observe availability of client service charter*	3. Client service charter available 1. Client service charter not available	Client service charter	*Administration*		
		2. Is the client service charter displayed in a public area and visible to clients at the hospital? *Observe availability of clients service charter and visibly displayed*	3: Client charter is displayed 1: Client charter is not displayed	Client service charter	*OPD* *Emergency* *Labour Ward*		
7.1.2	Client service charter is monitored	Does the facility management team measure compliance with the client service charter? *Check if documented within the last six months*	3. Compliance with client charter is assessed and measured by the facility management team 1. No assessment or measurement of compliance with the client charter	Observation Document	*Administration*		
7.1.3	Client feedback mechanism and complaint handling	1. Is any method for client feedback in place at the hospital? *Any of the following will qualify: suggestion box, client help desk, display of contact details for phone or SMS feedback. Specify the method(s) in use.*	3: Feedback method in place 1: No feedback method in place	Records of complaints/ suggestions	*Administration*		
		2. Is the feedback mechanism in use? *Check records of complaints/ suggestions over the last 3 months*	3. Records indicate a feedback method is used 1. No records in the last 6 months, feedback mechanism not working	Records of complaints/ suggestions	*Administration*		
		3. Has there been any action on suggestions for improvement or to address complaints from the feedback mechanism? *Check documentation on actions*	3. There is a record of actions to take up suggestions/ address the complaints 1.There is no record of action or no feedback mechanism	Documentation on actions	*Administration*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		4. Is there any community participation and engagement arising from the feedback mechanism? *Check if community members, HAB or community worker are involved in feedback mechanism*	3. Community engaged, or information shared 1. No engagement or sharing of information	Check RRHAB function	*Administration*		
7.2	**Client satisfaction**						
7.2.1	Clients satisfied with services provided	1.Are clients satisfied with their visit to the facility? *Conduct a structured interview of 10 patients selected from various service points (use average score for 10 patients)*	3: Clients satisfied with the service Score of 8 or more 2: Clients partially satisfied with the service score 5 to 7 1: Clients not satisfied with the service score less than 5 record their comments and suggestions for improvement of services. *Inform the facility staff during the feedback session.*	Exit interview questionnaire Annex 10	*OPD*		
Area 8: Social Accountability							
8.1	**Social Accountability Assessment**						
8.1.1	Hospital addresses local concerns	Does the Hospital Management Team plan specific interventions to address local health concerns and improve services? *Check CHOP to verify interventions which address local community concerns related to health care delivery.*	3. Meeting minutes /reports shows intervention /steps to address local health problems identified from the local community 2: Reported but intervention method is not appropriate 1. Meeting minutes/reports does not show intervention /steps to address local health problems identified from the local community	Minutes and reports	*Administration*		
8.1.2	Community participates in facility planning process	Is the community engaged during the process of annual planning by the hospital? *Check the minutes from hospital meetings for preparation of annual plans in order to verify attendance of member of HAB*	3. Minutes of meetings show participation of members of HAB 1. Minutes of meetings show no attendance of HAB member	Pre-preparatory meeting minutes and attendance of member of HAB and other stakeholders	*Administration*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
8.2	**Functional Hospital Advisory Board**						
8.2.1	HAB is active and well oriented	1.Is there an updated list of HAB members including their contact information? *Check availability of updated list of HAB members with their contact information*	3: Updated list of members of HAB is available 1: No updated list of board members	List of members of HAB	*Administration*		
		2. Do HAB members attend scheduled/ extra ordinary meetings? *Check schedule and minutes over the last quarter*	3: Schedule and Minutes of HAB meeting in the last quarter available 2: There is schedule but not followed 1: No meeting of HAB was held in the last quarter, or no board	Schedule of the meeting Minutes of HAB meeting	*Administration*		
		3. Were HAB members adequately trained and oriented on their roles and responsibilities? *Check training or orientation report and confirm their roles and responsibilities HAB were adequately covered. Interview member of HAB if possible.*	3. Training/ orientation report of HAB members seen and adequate 2. Training/ orientation found to be inadequate 1. Training not seen or board/ committee nor current	Training or orientation report	*Administration*		
8.2.2	HAB Voices Community Concerns	Does the HAB receives opinions and give feedback to the represented community. *Check the minutes/agreed issues received and to be posted / correspondences of feedback with councils/public (last quarter)*	3: Minutes of HAB Meeting from last quarter show feedback given to respective councils /public 1: Minutes do not show feedback given to respective councils/public	Check notice board for feedback display Written letter from HAB to facility committees (RRHAB Guideline)	*Administration*		
Area 9: Hospital Infrastructure							
9.1	**Planned Preventive Maintenance (PPM)**						
9.1.1	Facility Staff trained on PPM and availability of Engineering Section	1. Is there staff trained on PPM and established functional engineering section/workshop/department? *Check if there is established Engineering section workshop/department OR contract with engineering company*	3: Staff trained on PPM/ Biomedical Engineer and established engineering section /workshop /department OR Service contract 1: No staff trained on PPM/ Biomedical Engineer and no established engineering section /workshop /department/ service contract	Observation	*Administration*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		2. Are hospital vehicles, equipment, machines and plants functioning and well maintained? *Check maintenance schedule and records*	3: All hospital vehicles, equipment, machines and plants are functioning and well maintained 2: 2/3 of hospital vehicles, equipment, machines and plants are functioning 1: Less than 2/3 of hospital vehicles, equipment, machines and plants are functioning	Maintenance Schedule and Reports Observation (Hospital vehicles)	*Administration* *Hospital Environment*		
9.1.2	Plan for preventive maintenance (PPM) implemented	1. Is an annual PPM plan available?	3. PPM plan seen 1. No plan available	PPM plan	*Administration*		
		2. Is a PPM implementation report available for the past 12 months?	3. PPM report available 1. No report available or no PPM plan	PPM implementation report	*Administration*		
9.2	**Buildings**						
9.2.1	Status of the Building and Repair	1. Is the hospital structure in a good state of repair? *Check if the hospital structure is in good state of repair with Structure which does not have leaking ceiling/roof or loose/missing roofing material, cracked external walls/doors*	3: Structure does not have leaking roof or loose/missing roofing material, cracked external walls/doors 2: One of the above defects is present 1: More than one of the above defects are present	Observation of outside of building (roof, wall, door)	*Hospital Environment*		
		2. Is the condition and appearance of the facility walls good?	3. Well painted and clean without cracks 2. In need of minor repairs or repainting 1. Both repairs and repainting are needed	Observation (roof, wall, door)	*Hospital Environment*		
9.2.2	Functional Improved Toilets for Male and Female Patients and Staff	1. Does this hospital have male and female toilet in service areas? *Check and verify that one for staff, one for female patients, and one for male patients accessible and functional – in every service areas.*	3: all departments have functional and accessible toilets 2: Less than 5 departments have functional and accessible toilets 1: Less than 3 departments have functional and accessible toilets	Observation	*Internal Medicine W* *Surgical W* *Labour W* *Paediatric W* *Ob & Gy W*		
		2. Is there disability friendly toilets in designated areas. *Check and verify that at least two toilets are accessible by male and female patients with disability, respectively.*	3: Hospital has at least 2 disability friendly toilets 2: Hospital has 1 disability friendly toilets 1: No disability friendly toilets	Observation	*Hospital Environment*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		3. Do toilets have hand-washing facilities? *Check for elbow operated taps, running water and liquid soap*	3: Hand washing facilities available in 5 departments 2: Hand washing facilities available in less than 5 departments 1: Hand washing facilities available in less than 3 departments	Observation	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
9.2.3	Functional plumbing, drainage and sewage system	1. Are pipes free of leaks and elbow operated water taps are functioning? *Ask/observe the functionality of the taps (If facility have proper maintained*	3: Elbow operated Water taps functioning and no leakage at 5 departments 2: Elbow operated Water taps functioning and no leakage at less than 5 departments 1: Elbow operated Water taps functioning and no leakage at less than 3 departments	Observation	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
		2. Are there defects in the drainage/ sewage system, e.g. leakage, blockage? *Ask/observe the functionality of the drainages*	3: All 5 departments are well functioning 2: 3 department are well functioning 1: less than 3 department are well functioning	Observation	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
9.2.4	Patient privacy is maintained	*Check and report if audio and visual privacy is ensured in:* 1. Consultation/counselling rooms	3. Separate consultation/counselling room with closable door for each clinician 1. Above not present	Physical Check	*OPD*		
		Check and report if audio and visual privacy is ensured in: 2. Delivery room	3. Curtains to separate delivery beds or separate rooms or screen 1. None of the above	Physical Check	*Labour Ward*		
		Check and report if audio and visual privacy is ensured in: 3. Observation room/inpatient ward	3. Screens available and used 1. No screens or screens not used	Physical Check	*Internal Medicine Ward*		
9.2.5	Availability of conducive waiting area	Is there sufficient space, furniture, and roof covering for the waiting area? *Check the availability of sufficient space, furniture and roof covering for the waiting area*	3: Waiting area adequate in space, furnished with benches, covered/roofed in all selected area 2: there are in some selected area 1: Any one of above is absent in all selected area	Observation	*OPD* *Laboratory* *pharmacy* *X ray*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
9.2.6	HF rooms are well ventilated and well-lit as per HFs guidelines	Are all the rooms well ventilated and well lit? *Check if all the rooms are well ventilated*	3: All rooms well ventilated and well lit 2: Some rooms well ventilated or well lit 1: Rooms are not well ventilated nor well lit	Observation	*Laboratory* *pharmacy* *X ray* *Treatre*		
9.2.7	Disability-friendly facilities	Do the buildings have ramps for easy access by physically challenged patients? *Check if buildings can easily be accessed by physically challenged patients*	3: Buildings can be easily accessed by physically challenged patients 1: Buildings cannot be easily accessed by physically challenged patients	Observation	*Hospital Environment*		
9.2.8	Proper facilities for healthcare workers	Are there proper facilities for health workers namely changing room, bathroom and tea room? *Check if there are proper facilities for health workers namely changing room, bathroom and tea room.*	3: All areas have proper facilities 2: Three of the areas have proper facilities 1: No area has proper facilities	Observation	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
9.3	**Utilities**						
9.3.1	Availability of reliable water supply	Are there alternative water storage facilities in case of emergency, i.e. water reserve tanks. *Observe the availability of water storage*	3: Alternative water storage facilities available to sustain the services provision with enough capacity for the hospital 2: Available but not enough capacity 1: No water Storage facilities	Observation	*Hospital Environment*		
9.3.2	Reliable electrical power supply	1. Is there a back-up power source (stand-by generator with automatic switch-over or solar)? Capable to supply 100% of the facility. *Check if there is functioning back-up power source (stand-by generator with automatic switch-over or solar)*	3: There is a available and functioning back-up power supply with enough capacity for the hospital 2: Available but not enough capacity 1: There is no back-up or back-up is not functioning	Observation	*Hospital Environment*		
		2. Are action taken to reduce/save all possible costs on electricity?	3. Action taken to reduce/save all possible costs on electricity in all areas 1. No action taken to reduce/save all possible costs on electricity	Observation	*Hospital Environment*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
9.4	**Equipment and Furniture**						
9.4.1	Essential equipment and furniture for health care delivery is available	Are standard essential medical equipment, instruments and furniture available? *Check Annex 5 whether the list of necessary items is available*	3: All items are available in all department and arranged in good flow 2: 80% equipment is available in at least three department 1: More than 20 % of equipment is not available	Annex.5 (Standard Equipment and Furniture List)	*Laboratory* *Pharmacy* *X ray* *Labour Ward* *Emergency*		
9.4.2	Proper parking place	Are there proper parking places for vehicles, motorbikes and bicycles allocated for visitors and staff as well as official vehicles? *Check parking place is established with safety regulations, speed limit and instructions*	3: Parking place is established with safety regulations (e.g. safety regulations, speed limit and instructions), with enough parking space (100 vehicle, 50 motorcycles and 5 motor vehicles for physically challenged persons). 2: Parking place is not sufficient and/ or no safety regulations and instructions 1: No parking place is established	Observation	*Hospital Environment*		
Area 10: Ipc, Safety Measures And Risk Management							
10.1	**Infection Prevention and Control (IPC)**						
10.1.1	Hospital and its surroundings are clean	1.Are the hospital and its surroundings kept clean to prevent health care associated infections? *i) Inspect to observe whether grass has been cut, free of litter and/or pests,* *ii) Inspect areas such as roofs, walls, windows and floors for cleanliness* *iii) inspect whether there are sufficient lined dustbins for general waste in outdoor areas to avoid littering.*	3: No long grass, litter, rodents, bats, household pests, domestic animals and roofs, walls, windows floors are clean, sufficient dustbins 2: Some areas are not well organized, insufficient dustbins 1: If any of the following is found: - tall grass, litter, rodents, bats, household pests, domestic animals and dirty roofs, walls, windows and floors	Observation	*Hospital Environment*		
		2. Are all unnecessary items identified and removed from the workplace? *Observe if the work place has unwanted/ unfunctional items* *Check 5S approach used to manage work environment*	3: The workplace has no unwanted / unfunctional items in all selected department 2: The workplace has no unwanted / unfunctional items in some selected department 1: The workplace is surrounded with unwanted /unfunctional items	Observation	*Laboratory* *pharmacy* *Surgical Ward* *Labour Ward* *Emergency*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		3.Are all items well arranged in consideration with efficient and effective workflow/process in each place? *Observe the arrangement of items with efficient and effective workflow/ process with proper usage of 5S tools such as labelling, zoning, numbering, color coding, etc.*	3: All items are properly arranged in consideration with efficient and effective workflow /process, and proper use of 5S tools in 5 departments 2: Some of items are properly arranged in consideration with efficient and effective workflow/process, and improper use of 5S tools in 5 departments 1: No items are arranged in consideration with efficient and effective workflow/process	Observation	*Laboratory* *Pharmacy* *Surgical Ward* *Labour Ward* *Emergency*		
		4.Is cleaning done properly or not? *Check if there is a cleaning schedule* *Observe/Ask if cleanliness is done,* *- with proper cleaning materials* *- Cleaning materials are segregated according to the purposes* *- waste segregation is done properly*	3: Cleaning schedule is displayed, workplace and items are clean, and cleaning is done with proper materials, timely and waste segregation is done properly 2: one of the above items missing e.g. no proper cleaning materials or no waste segregation 1: 2 of the items missing in all selected department	Observation	*Laboratory* *Pharmacy* *Surgical Ward* *Labour Ward* *Emergency*		
10.1.2	Antiseptics and disinfectants are available	1. Are recommended/standard antiseptics and disinfectants available in functional areas according to National IPC Guidelines? *Verify availability of the recommended antiseptic and disinfectants on (See Annex.6)*	3: Has both types of antiseptics (a and b) plus disinfectant 2: Has one antiseptic and one disinfectant 1: Has no antiseptic and no disinfectant	Refer to Annex 6	*Operation Theatre* *Labour Ward* *Emergency*		
		2. Are the antiseptic and disinfectants stored and used according to the IPC guidelines? *Observe if antiseptics and disinfectants are: stored in lockable cupboard, in the lowest shelves, away from light; antiseptics are prepared in small quantities at a time, sufficient for each patient*	3: Antiseptics and disinfectants stored in lockable cupboard, in the lowest shelves, away from light, and antiseptic are prepared in appropriate quantity in all selected department 2: Following IPC guideline in some selected department 1: Any one of the above is not done in all selected department	Observation	*Operation Theatre* *Labour Ward* *Emergency*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
10.1.3	Accidental exposure to blood and body fluids handled	1. Does the facility provide PEP?	3. The hospital provides PEP services 1. The hospital does not provide PEP services	Interview	*Operation Theatre* *Labour Ward* *Laboratory*		
		2. Are PEP guidelines and SOPs available? *Interview if Staff are aware of SOPs and guidelines?*	3. Have PEP guidelines and SOPs, staff are aware 1. No PEP guidelines or SOPs	PEP Guidelines and SOPs available	*Operation Theatre* *Labour Ward* *Laboratory*		
		3. Is there a PEP register and monthly summary forms?	3. Have all PEP tools available 1. One or more of the tools not available	PEP register and forms available	*Supervisor (Matron)* *CTC* *Operation Theatre* *Labour Ward* *Laboratory*		
10.1.4	Safe injection use	Do healthcare workers adhere to IPC practices while giving injections? *Verify by observation or by simulation if no procedure observed: considers the 9R's right: patient, medicine, time, route, dose, injection device, formulation, storage and disposal of needle and syringe in a safety box immediately after procedure.*	3. Healthcare workers adhere to the 9R'sN. 1. Does not adhere to the 9R's	Observation or simulation	*Operation Theatre* *Labour Ward* *Emergency*		
10.1.5	Instrument sterilization or high-level disinfection	1. Are there procedures and requirements for instrument cleaning and decontamination? *Check for "three buckets system", SOPs and the use of 5S tools to differentiate the buckets*	3: SOPs available for decontamination, 3 buckets available with strengths and dates of preparation of disinfectants in all selected department 2: There is in some selected department 1: No SOPs for decontamination, no 3 buckets with strengths and dates of preparation of disinfectants	3 buckets available, SOPs, 5S tools	*Operation Theatre* *Labour Ward* *Emergency*		
		2. Does the facility has Central Sterile Supply Department (CSSD)? *Check availability of CSSD or scattered sterilisation points in various departments. (Refer to National IPC Standards for Hospitals 2012 / National IPC Guideline)*	3: The facility has fully functional CSSD. 2. The facility has scattered sterilisation points in various departments. 1: The facility has no CSSD and scattered sterilisation points in various departments.		*CSSD*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		3. Is sterilization or high-level disinfection done according to IPC guidelines? *Check availability of functional autoclaves and SOPs. Check work flow and arrangement of CSSD if it follows IPC guidelines*	3. SOPs available for high level disinfection and sterilisation and SOPs adhered to. 1. SOPs not available and/ or not adhered to.		*CSSD*		
		4. Is sterilization or high-level disinfection done according to IPC guidelines? *Check availability of functional autoclaves and SOPs*	3: Functional autoclave(s) and SOPs are available for high level disinfection and sterilization and SOPs are adhered to 1: No functional autoclave or SOPs and/or SOPs not adhered to	IPC guidelines and SOPs	*CSSD* *Laboratory*		
10.1.6	Personal protective equipment used	Is there Personal Protective Equipment (PPE) in related areas? *Check the availability and use of:* *i) gloves (clean and surgical),* *ii) gynaecological gloves,* *iii) heavy duty gloves,* *iv) masks, v) aprons,* *vi) goggles and face shield, vii) boots*	3: All PPE are available in related areas 2: Only 1 item is missing or PPE available but staff not using e.g. administering injection without gloves 1: More than 1 item is missing in related areas	PPE	*Operation Theatre* *Labour Ward* *Emergency* *CSSD* *Laboratory*		
10.1.7	Laundry services	1. Does the hospital have all necessary facilities and functioning equipment or valid contract for laundry services based on IPC guideline? *Check availability of:* *i) laundry room/area as per guideline,* *ii) reliable water supply,* *iii) washing detergents,* *iv) working tables,* *v) functioning laundry and ironing machines,* *vi) Or valid contract for laundry services based on IPC guidelines,* *vii) Use of 5S tools to demarcate and manage work areas to assure safety and productivity*	3: Facility has laundry room/area as per guideline and all necessary facilities and functioning equipment or valid contract for laundry services 1: No laundry room/area or some missing necessary facilities and functioning equipment and no valid contract	Laundry facilities, SOPs, 5S tools	*Laundry*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		2. Does the hospital handle linen according to IPC guidelines? *Check/ask how linens are handled according to National IPC Guideline (For facilities with contracts observe movement of linen)*	3: The linens are handled according to IPC guidelines 1: The linens is not handled according to IPC guidelines	Observation	*Laundry*		
10.2	**Healthcare Waste Management**						
10.2.1	Waste segregation equipment and supplies	1. Does the hospital have equipment for waste segregation? *i)Colour coded bins* *ii)Disposable colour coded bin liners* *ii)Stainless steel bin for transporting placentas to placenta pit* *iv)Safety/ sharps boxes* *Observe if facility has required equipment for waste segregation (If the facility is incinerating the placentas, plastic bin with red liner is acceptable)*	3: All necessary equipment is available 1: One item missing	Observation	*Hospital Environment*		
		2. Are the colour coded bins with matching liners used correctly? *Observe if colour coded bins with colour coded liners placed in waiting areas, corridors and all service points and check for proper segregation of waste*	3: Colour coded bins with matching liners are placed in waiting rooms, corridors and all patient areas, service points. waste is properly segregated 2: Colour coded bins with no colour coded bin liners OR waste not segregate properly 1: No colour coded bins or no matching liners are placed in waiting rooms, corridors and all patient areas, service points	Observation	*Hospital Environment*		
		3. What is the action taken to improve waste segregation at the section/ unit level? *Check whether the subject of waste segregation improvement is discussed in WIT meetings* *Check whether KAIZEN actions are taken for improvement of waste segregation*	3. KAIZEN actions are taken, and evidence of improvement are seen 2. Recognition of problems with waste segregation but no KAIZEN actions 1. No recognition of the problems		*Operating Thetres* *Laboratory* *Labour Ward* *Surgical Ward* *OPD*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		4. Is waste storage point established for non-infectious and infectious materials with proper colour coding? *Observe if the waste storage point is established and properly segregated according to color coding for non-infectious and infectious materials*	3: Waste storage points are established based on the categories of medical wastes with colour code and fenced 2: Established but no color-coding 1: Waste storage points are not established and no rules for storage medical wastes		*Hospital Environment*		
10.2.2	Healthcare Waste Disposal Facilities	Is there a functional Hitech incinerator and placenta pit; OR a waste removal and disposal contract? *Check the availability and functionality of Hitech incinerator and placenta pit; OR a waste removal and disposal contract*	3: The hospital has functional Hitech Incinerator and placenta pit; **OR** has waste removal and disposal contract 2: The hospital has no functional Hitech Incinerator but has a placenta pit 1: The hospital has none of the above		*Hospital Environment*		
10.2.3	Availability of cleaning materials	Are the cleaning materials and tools available and stored in line with the IPC standards; (mops, buckets, squeezers, brushes, etc.)? *Check if cleaning materials and tools are available and are stored properly by following the National IPC standards, and usage of 5S tools*	3: All cleaning materials and tools are available and stored according to the IPC standards and effective use of 5S tools 2: Only Some of cleaning materials and tools are available but stored according to the IPC standards 1: Cleaning materials and tools are not stored in line with IPC standards	Observation	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
10.2.4	Hand washing facilities in all service areas	1. Do all service areas have running water with elbow operated tap and liquid soap? *Check availability of running water with elbow operated tap and liquid soap*	3: All service areas have running water with elbow operated system and liquid soap. 2: Some service areas have running water with elbow operated system and liquid soap. 1: Not all service areas have running water, or elbow operated cork, or liquid soap	Running water elbow operated tap, liquid soap	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		2. Is hand washing and hygiene performed as per SOP? *Observe hand washing and hand scrubbing SOPs displayed (by simulation if no procedure observed)*	3: Hand washing SOPs displayed and they are adhered to in all selected department 2: Adhered in some selected department 1: No SOPs displayed and/or not adhered to in all selected department	Hand wash SOPs displayed in theatre, Hand Scrubbing SOP should be displayed	*Internal Medicine Ward* *Surgical Ward* *Labour Ward* *Paediatric Ward* *OBS & GYN*		
10.3	**Fire Safety**						
10.3.1	System to ensure fire safety	Does the hospital have a system to ensure fire safety? *Check that the hospital has an emergency exit clearly indicated, firefighting equipment (fire extinguishers with up to date inspection and servicing) and fire safety certificate and ask to some staff how to use firefighting equipment, evacuation procedures displayed and understood by HCWs*	3.The hospital has all features and staff knows how to use 2. The hospital has all features except one 1. The hospital is missing more than one feature.	Physical check interview to some staff	*OPD* *Laboratory* *Pharmacy* *Internal Medicine Ward* *Surgical Ward*		
Area 11: Clinical Services							
11.1	**Outpatient services**						
11.1.1	Outpatients are treated according to standard treatment guidelines	Are outpatients treated according to standard treatment guidelines? *Observe 5 cases in outpatient clinic to determine adherence to treatment guidelines*	3: All five patients treated according to current guidelines 1: Less than 5 patients treated according to guidelines	Observe OPD Register	*OPD*		
11.1.2	Good patient-Provider interaction.	Is there good patient-provider interaction? *Observe five cases to determine whether health care provider interaction with the patient follows good practices:* *1. Provider is friendly and courteous* *2. Full history taken* *3. Patient fully examined* *4. Informed about their diagnosis and treatment* *5. Sufficient time for the contact*	3: All five good practices are observed 2: Only 2-4 good practices are observed 1: Less than 2 good practices are observed	Observation of provider patient's interaction & review of patients records	*OPD*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
11.2	**RMNCH-Services**						
11.2.1	ANC RMNCH services follow guidelines	1. Are ten partographs of mothers filled correctly? *Check if partographs are accurately filled, interpreted and action taken on time*	3: All the partographs filled correctly 2: Only 8-6 partographs filled correctly 1: Below 6 partographs filled correctly	Partographs	*Labour Ward*		
		2. Is Maternal and perinatal deaths notification and documentation done within 48 hours? *Check the Maternal death audit reports*	3: Reports show facility perform maternal and perinatal deaths notifications within 48 hours 2: Notification over 48 hours 1: No notification done /documented	Maternal audit reports	*Labour Ward* *OBS & GYN*		
		3. Is Maternal and perinatal deaths reviews (audit) being done within 7 days of occurrence of maternal and perinatal deaths? *Check the Perinatal death audit reports*	3: Reports show facility perform maternal and perinatal deaths reviews within 7 days 2: Reviews done over 7 days 1: No reviews done / not documented	Perinatal audit reports	*Labour Ward*		
11.3	**Inpatient Services**						
11.3.1	Inpatients are treated according to standard treatment guidelines	1. Are inpatients treated according to standard treatment guidelines for: Severe Malaria? *Review ward round reports/to verify adherence to treatment guidelines*	3: All three patients treated according to current guidelines 1: Less than 3 patients treated according to guidelines	Ward round reports books	*Internal Medicine Ward*		
		2.Are inpatients treated according to standard treatment guidelines for: Severe pneumonia? *Review ward round reports/to verify adherence to treatment guidelines*	3: All three patients treated according to current guidelines 1: Less than 3 patients treated according to guidelines	Ward round reports books	*Internal Medicine Ward*		
		3. Are inpatients treated according to standard treatment guidelines for: Diabetes? *Review ward round reports/to verify adherence to treatment guidelines*	3: All three patients treated according to current guidelines 1: Less than 3 patients treated according to guidelines	Ward round reports books	*Internal Medicine Ward*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		4. Are inpatients treated according to standard treatment guidelines for: Eclampsia? *Review ward round reports/to verify adherence to treatment guidelines*	3: All three patients treated according to current guidelines 1: Less than 3 patients treated according to guidelines	Ward round reports books	*Internal Medicine Ward*		
		5. Are inpatients treated according to standard treatment guidelines for: Essential Hypertension? *Review ward round reports/to verify adherence to treatment guidelines*	3: All three patients treated according to current guidelines 1: Less than 3 patients treated according to guidelines	Ward round reports books	*Labour Ward* *OBS & GYN*		
11.3.2	Nursing Care Plan in place	Is the basic nursing care observed? *Observation of 5 patients for the following:* *i) Review patient records/to check for proper documentation of vital signs* *ii) Adherence to medication schedule* *iii) Hygienic care to patients* *iv) Check for availability of nursing care plan*	3: All four items are observed in all 5 patients 2: 2-3 items are conducted in 5 patients 1: Less than 2 items are conducted or observed in less than 5 patients	Observation 5 Patients records	*Internal Medicine Ward*		
11.3.3	Intensive Care Unit Equipped	1. Is there an Intensive Care Unit including neonatal ICU in the hospital and is it adequately equipped? *Observe equipment in the ICU (ventilator, monitors for ECG, pulse, BP, NGT, endotracheal tube)*	3. The ICU and NICU available and all required items are available 2. The ICU available and all required items are available but no NICU 1.No ICU	Annex 5	*ICU*		
		2. Have the staff had Critical Care Training? *Check for presence of training reports for the staff*	3. All staff working in the ICU have had critical care training 1. not all staff working in the ICU have had training		*ICU*		
11.3.4	Medical Audit in place	The hospital has a system for tracking incident, accident and medical errors (wrong injection procedure; wrong medication; surgeries-wrong site, wrong patient, infections) etc. *Check that the hospital has documentation of incident, accident and medical errors from the previous year. Verify that the hospital uses the data to design intervention measures to address these errors. Check that the hospital has adverse drug reaction forms.*	3. The hospital has an active system for tracking incident, accident and medical errors including adverse drug reactions 1. The hospital does not have a system for tracking incident, accident and medical errors	Reports/ Documents	*Pharmacy* *OPD* *Internal Medicine Ward* *Surgical Ward* *Paediatrics* *Operation Theatre*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
Area 12: Clinical Support Services							
12.1	**Pharmaceutical Services**						
12.1.1	Qualified Pharmaceutical Cadre and Therapeutic Committee in place	1. Is the main dispensing point staffed by a qualified pharmaceutical cadre on the day of assessment? *Verify that the member of staff is a pharmacist, pharmacist technologist or assistant pharmaceutical technologist.*	3. Qualified pharmaceutical cadre 1. No qualified pharmaceutical cadre	Interview	*Pharmacy (and Dispensing Unit)*		
		2. Does the hospital have a functional Medicines and Therapeutics Committee? *Verify availability of list of members, reports and meeting minutes*	3: List, meeting minutes and reports are available 1: List is there but no minutes meeting or report	List of members Reports Meeting minutes	*Pharmacy*		
		3. Is there hospital formulary meeting? *Verify availability of reports and meeting minutes*	3: Meeting minutes and reports are available 1: No minutes meeting or report	Reports Meeting minutes	*Pharmacy*		
12.1.2	Good dispensing practice	Are there SOPs for dispensing? *See checklist for adequate SOP content and observe 3 cases for SOP adherence*	3: SOP for dispensing is adequate, displayed and adhered to 2: SOP for dispensing is displayed but content is inadequate and not adhered to 1: SOP for dispensing was not found	(Annex 11) with adequate SOPs for dispensing and 3 cases for SOP adherence	*Pharmacy*		
12.1.3	Availability of Essential Medicines and Health Products	Are 30 tracer medicines and health products or specified therapeutic equivalent available on the day of assessment? *Physically verify that the tracer is available for issue to clients. If available, tick box next to same as HMIS the checklist on Annex. 7.*	3: All 30 tracers available on the day 2: Between 20 and 29 tracers are available. 1: Less than 20 tracers are available	Annex 7 (Tracer Medicines) HMIS reports	*Pharmacy*		
12.1.4	Accountability for medicines issued to clients	Are registers properly completed for medicines dispensed or administered to clients and are auditable? *For each of the selected tracer products, check the entries in the dispensing and injection register for the previous day. It should be possible to cross-check the entries in the dispensing and injection register with the medicines prescribed for those clients, e.g. in the outpatient register.*	3: Dispensing records for all 3 tracer products are properly completed and can be audited against prescribing records. 2: One or more tracer items could not be audited. 1: No tracer item could be audited.	Dispensing registers, Ledger books	*OPD (Dispensing Unit)*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
12.1.5	Inventory management per ILS guidelines	1. Is the stock level appropriate for all three tracers? *Stock level is appropriate if there is 3-6 months of stock on hand (choose three tracers out of tracer medicine list. Annex 7)*	3: All three tracers appropriately stocked 2: Less than three tracers appropriately stocked, or inadequate records for the assessment. 1: No tracer	Annex. 8 (Checklist for Tracer Medicine).	*Pharmacy* *Internal Medicine Ward* *Surgical Ward* *Labour Ward*		
		2. Are the medicines/ medical commodities easily accessible and monitored in department/ ward? *Observe/ask*	3: Easily accessible and well monitored 2: Accessible and not monitored 1: Locked and not easily accessible.	Ledgers, bin cards, monitoring systems	*Pharmacy (Sub store)* *OPD (Dispensing)* *Internal Medicine Ward* *Surgical Ward* *Labour Ward*		
12.1.6	Appropriate storage and handling of medication	1. Are there appropriate storage facilities for medicines and supplies? *Check that the storage area is* *i) Secured room* *ii) Functional AC and well ventilated* *iii) protected from heat and sunlight* *iv) has adequate shelving or racking/pallets for boxes* *v) worktop for issuing and record keeping* *vi) well arranged, clean and spacious*	3: Storage area has appropriate facilities and is well organized. 2: Storage area has appropriate facilities but is not well organized. 1: Storage area lacks facilities and is poorly organized	Observation	*Pharmacy*		
		2. Are expired or unusable products handled according to guidelines? *Check if expired medicines and unusable health products are* *i) removed from the inventory* *ii) clearly marked* *iii) recorded (Check F15)* *iv) stored separately awaiting disposal*	3: Expired or unusable stock handled as per guidelines and regulations, or no expired or unusable stock. 1: Not handled as per guidelines and regulations	F15 Suspensory and Unserviceable good ledgers	*Pharmacy*		
		3. Is there functional and reliable refrigeration? *Check if:* *i) the fridge is working* *ii) there is a reliable power source (with back-up and no loss of refrigeration > 12-hour period)* *iii) Temperature monitoring records (Thermometer &charts)*	3: Functional and reliable refrigeration with temperature records 2: there is but no temperature record 1: Not functional or not reliable		*Pharmacy*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
		4. Is there secure storage and register for controlled medicines i.e. Dangerous Drugs Act (DDAs)? *Check for lockable cabinet or secure storage area that is dedicated for medicines controlled under the DDA's* *Check that there is a register for these items*	3: Secure storage and register for 'DDAs' 1: No secure storage or no register	i) lockable cabinet or secure storage area ii) register	*Pharmacy*		
12.1.7	Application of 5S/KAIZEN in Stock Management	1. Does RRHMT use 5S/KAIZEN approach for Medicine, Equipment, Medical Supply? *Verify by availability Reports of 5S and KAIZEN and by physical observation –application of 5S-KAIZEN*	3. Reports are available and there is physical evidence of implementation of 5S KAIZEN 1. No reports and/ or physical evidence	Reports of 5S and KAIZEN	*Pharmacy store, Dispensing area, Internal Medicine, OBS & GYN*		
		2. Are there 5S tools and visual control methods adopted for effective and efficient commodity management? *Check for 5S tools and Visual Controls (mention the visual controls)*	3: 5S tools and Visual control methods are adopted to all areas where health commodities are stored, with clear instructions how to use the methods 2: 5S tools and Visual control methods are adopted to limited areas 1: 5S tools and Visual control methods are not adopted	5S tools; Visual controls	*Pharmacy store, Dispensing area, Internal Medicine, OBS & GYN*		
		3. Is there action taken to minimize number of expired medicines and medical supplies? *i) Check medicines/products are arranged in FIFO and FEFO considerations and are adhered to* *ii) Use bin cards and store ledger*	3: Any action taken to minimize expired medicines and medical supplies 2: Problem was recognized but no action is taken 1: Problem was not recognized	Records (Bin cards, Ledger)	*Pharmacy*		
12.2	**Laboratory**						
12.2.1	Laboratory Accreditation	Is the laboratory accredited through SLMTA? *Check SLMTA report/scores*	3: 3-more stars 2: 1-2 Stars 1: 0-star	SLMTA report/scores	*Laboratory*		
12.2.2	Good Laboratory Practice	Are SOPs for all test and equipment use readily available for reference/ displayed and adhered to? *Ask /observe from the lab personnel*	3: SOP for tests and equipment available/ displayed and adhered to 2: SOP for tests and equipment available/ displayed but not adhered to 1: Not available and not displayed	Observation	*Laboratory*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
12.2.3	Established turnaround time for results	Is there a system to monitor turnaround time for lab tests performed? *Check for documentation of turnaround time for lab tests performed*	3: System in place and turnaround time documented per lab test procedures 2: System in place but no documented 1: No system to monitor turnaround time and no documentation	Observation	*Laboratory*		
12.2.4	Quality assurance and Control Processes for Tests	Is internal and external quality control done? *Check documentation/ register for quality control results and corrective and preventive actions in previous quarter*	3: Both internal and external quality controls are done 2: Only internal or external quality controls is done 1: None of the above is done	Quality control results and corrective and preventive actions in previous quarter	*Laboratory*		
12.2.5	Laboratory safety system in place	Are services provided according to IPC guideline and SOPs? *Observe if the above guidelines and SOPs are being adhered to*	3: IPC guideline and SOPs are available, accessible and adhered to 2: IPC guideline and SOPs are available, accessible but not adhered 1: IPC guideline and SOPs are not available	SOPs IPC guideline Other relevant guidelines	*Laboratory*		
12.2.6	Laboratory supplies management system in place	Is there a stock management system? i) *Check documentation (register of incoming and outgoing stock/EMR); verify at least 3 items are correctly recorded.* *ii) Check use of 5S tools for stock management*	3: Register of incoming and outgoing stock is available and at least 3 items are correctly recorded, and managed using 5S tools 2: Documentation is not up to date, less than 3 items 1: No register of incoming and outgoing stock and /or items are incorrectly recorded	Register of incoming and outgoing stock/ EMR	*Laboratory*		
12.2.7	Blood Transfusion system in place	Is there a functional blood transfusion service? *Check the availability of functional blood bank refrigerator, consumables and if hospital receive safe blood for transfusion*	3: Hospital has a functional blood transfusion services 1: No blood transfusion services	Observation	*Laboratory*		
12.3	**Operation Theatre**						
12.3.1	Protocols for surgical procedures and recovery are available	Are there protocols for operating theatre and are they adhered to? *Check if protocols for traffic flow, surgical procedures and recovery are available and adhered to*	3: Protocols for traffic flow, surgical procedures and recovery are available 2: One protocol available 1: Not all available.	Annex 12. OT protocol	*Operation Theatre*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
12.3.2	Surgical equipment to support effective provision of safe surgical intervention is available	Is there equipment to support safe surgical intervention appropriate to the level? i) *Check for the availability of the following equipment according to national guideline on Annex.5.* ii) *Check effectiveness of processes and procedures of getting the sterile equipment from CSSD*	3: All required equipment and check-list for sterile equipment are readily available 2: One equipment is missing but check-list is available 1: Two or more items are missing	Annex.5 (Standard Equipment and Furniture List)	*Operation Theatre*		
12.3.3	Emergency resuscitation and airway management equipment is available and functioning	Is emergency equipment available and functioning? *Check for the functionality of emergency equipment, Resuscitation and Airway Management System*	3: Emergency equipment is available and functioning. 2: there is but or non-functioning 1: Not all emergency equipment is available	Annex. 9 (Emergency Equipment List on OT)	*Operation Theatre*		
12.3.4	Systems in place for the prevention of surgical sepsis	Are the following OT protocols in place and observed for the prevention of surgical sepsis? *i) Designated areas for:* *- patient preparation* *- changing* *- scrubbing* *- operating and recovery* *ii) Controlled access and zones in the theatre* *iii) Washing and Decontamination area for used equipment and linen* *Check and visit.*	3: All areas are in place and OT protocols are observed 2: Limited areas are in place and OT protocols are observed 1: Areas are not in place/OT protocols are not observed		*Operation Theatre*		
12.4	**Radiology and Imaging**						
12.4.1	Availability and functionality of radiology and imaging services	1. Are there SOPs and protocols for equipment and procedures? *Check if radiology and imaging services have SOPs and protocols for all types of equipment including radiation warning symbols and posters*	3: SOPs and protocols for all types of equipment and procedures are available 1: No SOPs available		*X Ray*		
		2. Is the radiology and imaging equipment functional? *Ask and observe if the radiological and imaging equipment is working (should have X-ray, Ultrasound, ECHO cardiograph, CT-Scan)*	3: Radiology and imaging equipment is functional 1: Not all the radiology and imaging equipment is functional	X-ray, Ultrasound, ECHO cardiograph, CT-Scan	*X Ray*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
12.4.2	Availability of radiation safety program	1. Is the radiology department complying with the radiology safety program? *Check if there is a safety report and compare with the schedule of the radiology safety program (Tanzania Atomic Energy) Commission -TAEC)*	3: There is a current TAEC safety report 1: There is no radiology safety report	i) Annual license/ Document II) Safety report ii) Schedule of the TAEC radiology safety program	*X Ray*		
		2. Are the radiology staff using protective gears? *Check if staff have lead apron, radiation badges (TLDs), lead hand gloves, gonad lead protective devices*	3: Staff have lead apron, radiation badges (TLDs), lead hand gloves and gonad lead protective devices 1: One of more of the items above is not available	i) Lead apron ii) Radiation badges (TLDs) iii) Lead hand gloves iv) Gonad lead protective device	*X Ray*		
12.5	**Mortuary Services**						
12.5.1	Mortuary services are provided according to Guidelines	1. Are there appropriate facilities for preserving and preparation of dead bodies? *Check if there is a functioning refrigeration and availability of formalin for preserving dead bodies*	3: Functioning refrigerators and formalin are available 2: Functioning refrigerators available but inadequate 1: No functioning refrigerator/ no formalin		*Mortuary*		
		2. Does the health care facility follows safe practices for post-mortem procedures and mortuary services? *Check for the presence of essential post-mortem/autopsy equipment and SOPs*	3. All equipment and SOPs are available 2. At least half of the equipment and SOPs are available 1. Less than half of the equipment are available and no SOPs	Annex 13	*Mortuary*		
		3. Are appropriate PPE used when handling the dead body? *Check if the following PPE are available* *i) Gowns* *ii) Gloves* *iii) Plastic apron* *iv) Protective eye wear* *v) Face mask*	3: All PPE are available 2: Some of PPE are missing 1: Not all PPE available		*Mortuary*		

No.	Indicator	Question/ Verification Method	Responses	Means of Verification	Departments/Units	Score	Comments
12.6	**Food Services**						
12.6.1	Food services are provided according to IPC guidelines	1. Does the facility have a dedicated area/ structure (kitchen) to provide food services based on BSHFSWs? *Observe the structure and the equipment*	3: There is a dedicated area with dimensions stated in the BSHFV3 1: No dedicated area NA: Subcontracted with valid contract		*Kitchen*		
		2. Is food stored in a safe and clean environment? *Check for the availability of food storage such as cold storage room/refrigerator and store (dry store and vegetable store)* *Or valid contract for food services*	3: There is all storage facilities for food are available OR valid contract for food services 2: If one of them is present 1: If all are missing or food services NA: Subcontracted with valid contract		*Kitchen*		
		3. Are food handlers free of contagious diseases? *Check files of all food handlers' medical check-up certificates/reports (every 6 months) (For contracted companies tender document should specify screening of food handlers)*	3: All Food handlers have been screened for contagious disease (diarrhoeal, worms, skin infections) 2: Some of them are screened 1: All Food handlers have not been screened	Medical check-up certificates/reports	*Kitchen*		
		4. Are there sufficient cleaning facilities? *Observe the availability of sufficient cleaning facilities (water supply, soap, equipment, sink/ buckets and basins)*	3: All cleaning facilities are available 2: All cleaning facilities are available but not enough capacity 1: Cleaning facilities are missing NA: Subcontracted with valid contract		*Kitchen*		

Annex for Chapter 3-2: Reporting format of EHPA

REGION: _____

Facility Name: _____

Name of Assessors	Title	TEL

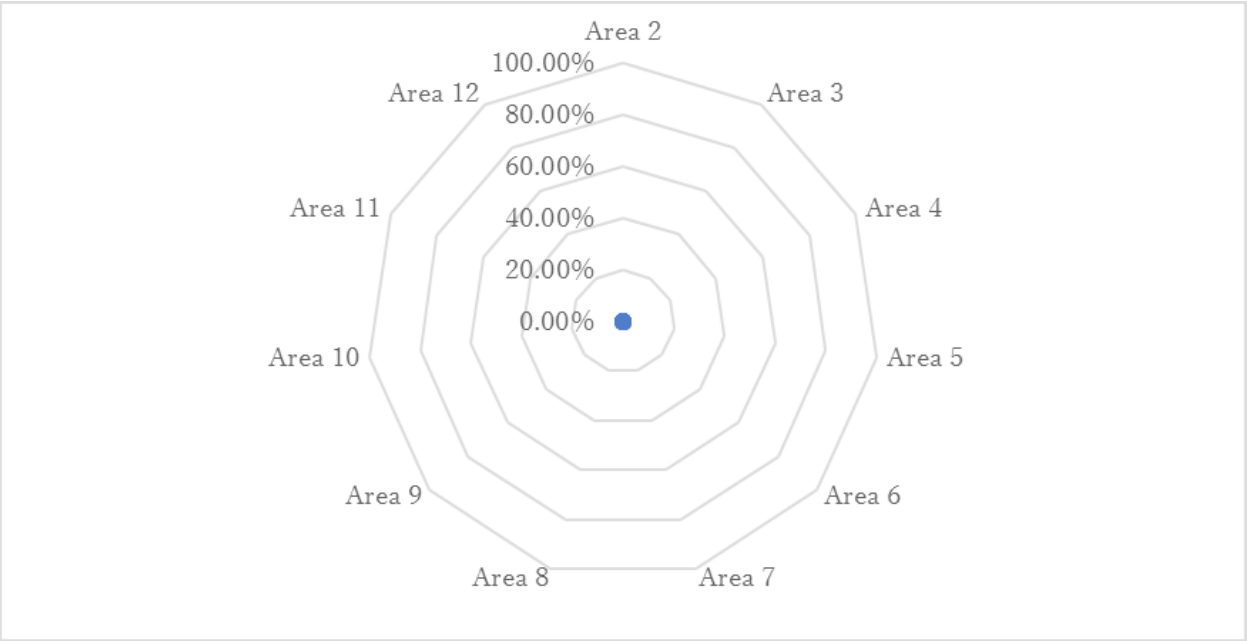
Date of Assessment _____

Facility Information			
No	**Question**	**Response**	**Remarks**
1	Facility Code		
2	Facility Name		
3	Facility GPS Code		
4	Facility Manager (In Charge) Name		
5	Facility Manager (In Charge) Qualification		
6	Facility Manager (In Charge) Tel. No Office		
7	Facility Manager (In Charge) Tel. No Mobile		
8	Facility Manager (In Charge) Gender (1: Male / 2: Female)		
9	What is the catchment population served by this facility?		
10	On average, how many outpatients seen each day? *From OPD register, calculate average from last two completed calendar months*		
11	On average, how many patients are admitted daily (From HMIS Book 14) *From IPD register, calculate average from last two completed calendar months*		
12	Bed capacity (total number of beds in the hospital)		
13	*Bed Occupancy rate in percentage* (Average number of admitted patients per year/total number of beds) × 100		

41 Results of EHPA

Name of Interviewee:

Area	Name	Score
Area 1	**Legality**	
Area 2	**Hospital Management**	
Area 3	**Use of Hospital Data for Planning and Service Improvement**	
Area 4	**Staff Performance Assessment**	
Area 5	**Organization of Service**	
Area 6	**Handling Emergency and Referral**	
Area 7	**Client Focus**	
Area 8	**Social Accountability**	
Area 9	**Hospital Infrastructure**	
Area 10	**IPC, Safety Measures and Risk Management**	
Area 11	**Clinical Services**	
Area 12	**Clinical Support Services**	
Average		



Area	Recommendations	Department/ Unit

Annex for Chapter 3-3: Required document for EHPA

It is necessary to check the availability of different documents, register book and records during the EHPA. Those are as follows;

In all department, availability of the following documents to be checked

1	Organogram of the department/unit	3	List of WIT member
2	Departmental/section meeting minutes/ records	4	Standard Operation Procedures (SOPs) and Guideline

In the selected department, availability of the following documents to be checked

1	Attendance register

In Outpatient Department (OPD), availability of the following documents to be checked

1	Procedures of referral system	2	Record of referred patients

In CTC. Laboratory and Theatre, availability of the following documents to be checked

1	PEP Guidelines,	3	PEP monthly summary form
2	PEP register	4	IPC guidelines

In Labour ward and Obstetrics & Gynaecology ward, availability of the following documents to be checked

1	Maternal audit report

In Pharmacy (Therapeutically committee), availability of the following documents to be checked

1	List of Membership, reports and meeting minutes

In Radiology and Imaging, availability of the following documents to be checked

1	Maintenance Log and service card	2	Safety report

In Medical Record, availability of the following documents to be checked

1	Medical Record (10 sample)

In Administration, availability of the following documents to be checked

1	Monthly RRHMT minutes	21	CHOP
2	Attendance Register	22	ISS report
3	Health Worker Sill Profile	23	HMIS summary book
4	Training needs assessment report	24	Data in OPD register
5	Succession plan	25	Tally sheets
6	Promotion plan	26	Hospital Analysis data
7	Human Resource retention program	27	OPRAS
8	RRHMT (ToR and Appointment letter, Meeting schedule and Minute of Meeting)	28	Staff records/file
9	Disciplinary committee, ToR, meeting minutes	29	Client waiting time monitoring record
10	Coaching and Mentoring report	30	Report of Health education activities

11	MoU between Colleges/Hospitals, reports	31	Schedule of Outreach services
12	Reports of 5S and KAIZEN	32	Record of Outreach services
13	Report of internal quality assessment	33	Triage report
14	The self-discipline instructions	34	Disaster responsiveness plan
15	Minutes of QIT meeting	35	Guidelines/manual for emergence preparedness and disaster responsiveness
16	5-year strategic Plan	36	SOPs for emergence preparedness and disaster responsiveness
17	Quarterly financial and technical reports (CHOP QR)	37	Client charter
18	Feedback report of Quarterly financial and technical reports	38	Records of complaints/ suggestions
19	Financial Audit Report	39	List of members of HAB
20	CHOP guideline	40	Minutes of HAB meeting

There are 14 checklists needed for EHPA implementation. Those are as follows:

1	Personnel List	8	Tracer Medicines
2	Revenue Collection Checklist	9	Checklist for Tracer Medicine in selected Department
3	Checklist of HMIS registers and related tools	10	Emergency Equipment List on OT
4	Emergency medicine checklist /	11	Client Exit Interview
5	Emergency equipment checklist	12	SOPs for Dispensing
6	Standard Equipment and Furniture List	13	Protocols for OT (Refer WHO 2007), Best Practice Protocols Clinical Procedures Safety
7	Recommend antiseptic and disinfectant	14	Essential Post-mortem/autopsy Equipment

1) Personnel list

No.	Cadres	Requirement Minimum Number	Available number	Reported at duty station	Sufficiency rate
1	Accountant	1			
2	Accounts Assistant	2			
3	Anaesthesiologist	1			
4	Assistant Accountant	1			
5	Assistant Dental Officer	3			
6	Assistant Environmental Health Officer	2			
7	Assistant Laboratory Technologist	6			
8	Assistant Medical Officer	24			
9	Assistant Nursing Officer	75			
10	Assistant pharmaceutical Technologist	5			
11	Assistant Physiotherapist	2			
12	Assistant Radiographer	2			
13	Assistant Supplies Officer	1			
14	Assistant Technician –civil	1			
15	Assistant Technician –Electrical	1			
16	Biomedical Engineer	1			
17	Biomedical Technician	1			
18	Cook	2			
19	Data Clerk	1			
20	Dental Laboratory technologist	2			
21	Dental Officer	2			
22	Dental Specialist	1			
23	Dental Therapist	2			
24	Drivers	8			
25	Environmental Health Officer	1			
26	Epidemiologist	1			
27	Health Laboratory scientist	1			
28	Health Laboratory Technologist	8			
29	Health Secretary	1			
30	ICT Technician	4			
31	Kitchen Attendant	2			
32	M&E Specialist	1			
33	Medical Attendant	98			
34	Medical Officer	30			
35	Medical Record Technician	2			
36	Medical recorder	1			
37	Mortuary Attendant	2			
38	Enrolled Nurse	91			
39	Nursing Officer	31			

No.	Cadres	Requirement Minimum Number	Available number	Reported at duty station	Sufficiency rate
40	Nutritionist	2			
41	Obstetrician / Gynaecologist	4			
42	Occupational Therapist	1			
43	Ophthalmologist	1			
44	Optometrists	2			
45	Paediatrician	2			
46	Personal Secretary	1			
47	Pharmaceutical Technologist	3			
49	Pharmacist	1			
50	Physiotherapist	1			
51	Procurement & Supplies Officer	1			
52	Prosecutor (Mortuary)	1			
53	Radiographer	1			
54	Radiologist	1			
55	Security guard	12			
56	Social Welfare Officer	6			
57	Technician (Prosthetic)	1			
58	ENT surgeon	1			
60	Orthopaedic surgeon	1			
61	Psychiatrist	1			
62	General Surgeon	3			
63	Physician	3			
Total Number of staff for RRH		**471**			

2) Revenue Collection Checklist

No.	Revenue collection Methods	Availability
1	Installation of Electronic Revenue Collection	
2	Incentive- NHIF, cost sharing, Improved CHF	
3	Exploitation of other health insurance providers. e.g. NSSF	
4	Transparency in financial reporting	
5	Sufficient number of Collection points	
6	Regular monitoring of cash collectors	
7	Rotation of cashiers	
8	Orientation/ training how to fill NHIF forms for all necessary staff etc.	
9	KAIZEN Activities	
10	Donation campaigns	
11	Request letter to MoHCDGEC of Development Partners, NGO, etc. in the last quarter?	

3) Checklist of HMIS registers and related tools:

HMIS Book/Register for specified service	*Register or book*	*Tally Sheet*	*Summary Form*
1 - Book 4. Ledger book (pharmacy)			
2 - Book 5. Outpatient register			
3 - Book 6. Antenatal care register			
4 - Book 7. Child register			
5- Book 8. Family planning register			
6 - Book 9. Diarrhoea treatment corner			
7 - Book 10 Monthly report book			
8 - Book 11. Dental register			
9 - Book 12. Labour and delivery register			
10 - Book 13 Postnatal register			
11 - Book 14- Inpatient department register			
12 - Tracer Medicine Form			
13 - Death Form			

4) Emergency medicine checklist

No.	Name of medicines	Availability
1	Oxygen and functional delivery apparatus or Oxygen concentrator	
2	IV Dextrose 10%, 25% and 50%	
3	Benzyl penicillin or Ampicillin injection	
4	IV Fluids (NS, DNS, RL, 5% Dextrose, Mannitol)	
5	IV Ceftriaxone	
6	Ketamine injection	
7	Midazolam injection	
8	Propofol injection	
9	Pancuronium injection	
10	Pethedine injection	
11	Diazepam tabs/injection	
12	Phenobabitone tabs/ injection	
13	Artesunate injection	
14	IV Potassium chloride	
15	Magnesium Sulphate injection	

No.	Name of medicines	Availability
16	Calcium Gluconate injection	
17	Insulin injection	
18	Salbutamol inhaler	
19	IV Furosemide	
20	IV Adrenaline	
21	IV Hydrocortisone	
22	Salbutamol nebulizer solution	
23	Hydrocortisone injection	
24	Nitroglycerine injection	
25	IV/IM Hydralazine	
26	Units of Blood	
27	Anti-sera for blood grouping	
28	Pantoprazole (Rebaprazole Injection)	
29	Digoxin tabs	
30	Propranolol Hydrochloride tabs	
31	Atropine Sulfate injection	
32	Lidocaine injection	
33	Acetylsalicylic acid tabs	
34	Heparin injection	
35	Activated Charcoal	
36	Naloxone injection	
37	Snake Venoum Antiserum injection	
38	Oxytocin injection	
39	Water for injection	
40	Emergency contraceptives tabs	
41	Sutures	

5) Emergency equipment checklist

No.	Name of equipment	Availability
1	Ambu bag and mask of different sizes	
2	Catheters	
3	Suction machines and suction tubes of different sizes	
4	Nasogastric tubes (paediatric and adult)	
5	Needles and syringes (Paediatric and adult)	
6	Cannulas (paediatric and adult)	
7	Thermometer	
8	Glucometer and sticks	

No.	Name of equipment	Availability
9	Tourniquet	
10	Surgical gloves	
11	Chest tubes	
12	Surgical tray	
13	Stretchers-5 and wheelchairs-3	
14	Salbutamol nebulizer	
15	Patient monitors	
16	Oxygen and functional delivery apparatus or Oxygen concentrator	
17	Penguin suckers	
18	BP machines	
19	Stethoscope	
20	Defibrillators	
21	ECG machine	
22	Baby warmers	
24	Portable examination lamp	
25	Portable digital X-ray	
25	Diagnostic kit (Otoscope, Ophthalmoscope, Tape measure, Pattela and Hammer)	
26	Gynecological Examination Table	
27	MVA set	
28	Ultrasound	

6) Standard Equipment and Furniture List

Department/Unit	Name of equipment	Availability
Consultation and Counselling rooms	Clinical thermometers	
	Tongue depressors	
	Screen four folds	
	Guided Airways Adults and Children	
	Table with chair	
	Examination table	
	Examination bed and screen	
	Office table and two chairs	
	BP machine/ Sphygmomanometers	
	Stethoscope	
	Vaginal Examination tray	
	Sink for hand washing	
	Foetoscopes /Doppler	

Department/Unit	Name of equipment	Availability
	Diagnostic kit with pen torch, patella hammer, laryngoscope, tape measure, tuning fork, otoscope and spatula.	
Pharmacy Store	Shelves for drug storage	
	Pallets (or equivalent to keep boxes above floor level)	
	Air conditioner/fan/a well-ventilated room (Temperature control)	
	Table with chair	
	Stores Ledger/Combined Requisition and Issue Voucher	
	Functional refrigerator	
	Secure DDA Cupboard	
Dispensing room	Shelf	
	Drug dispensing book	
	Counting trays	
	Dust bin	
	Sink for hand washing	
	Chair	
	Colour coded bins	
	Dispensing window	
	Vomiting bowl	
VTC / CTC	Table with chair	
	Examination table	
	Stethoscope	
	BP machine	
	Weighing scale	
	Thermometer, otoscope, pen torch	
Injection room	Patient bed	
	Dressing trolley	
	Medicine trolley (Injection trolley)	
	Bowl stand	
	Kidney dishes (Large: 2, Medium: 2, Small: 2)	
	Galipot	
	Dressing drum assorted sizes	
	Jar forces with 2 cheatle forces	
	Buckets	
Dressing room	Instrument trays (different sizes)	
	Dressing drums: (Deep large: 1, Deep small: 1, Shallow large: 1)	
	Bowls (different sizes)	
	Galipots	
	Trolley	
	Cheatle forceps	
	Dressing tray	
	Buckets	

Department/Unit	Name of equipment	Availability
	Sterilizer electric	
	Sink/Running water	
Laboratory	Running water with water basins, and established drainage system.	
	Haematology Analyser/Full blood picture machine	
	Chemistry Analyser	
	Water Distiller/filler	
	At least 2 microscopes, and slides, Stool microscopy	
	Reagents for malaria test, plus mRDT	
	Tuberculosis microscopy	
	Urinalysis, haemoglobin testing (Haemocue machine)	
	CD4/CD8 Counts	
	ELISA reader/washer manual	
	Diagnostic Kits (Hepatitis, Syphilis, Widal test, H. Pylori test,)	
	Refrigerator with freezing compartments.	
	Hot air oven/ Autoclave	
	Centrifuge Machine	
	Incubator for culture/sensitivity process	
	Glucometer	
	Dried blood spot collection	
	Blood grouping test, refrigerator for blood	
	Tubes for blood collection	
	Weighing scale	
RCH	Clinical thermometers	
	Stethoscopes	
	Examination bed	
	Functioning adult weighing scale (1 Adults, 1 Children)	
	Height measuring rod	
	BP machine	
	Immunisation refrigerator/trays	
	Foetoscopes/Doppler	
	Delivery set	
	Tape measure	
	Diagnostic kit (VDRL/RPR, MRDT, Hb, Urine Diagnostic strips)	
Delivery room	Four complete delivery beds with Mackintosh	
	Buckets with lids for soiled linen and swabs (IPC)	
	Foetoscopes: 4 and Doppler: 1	
	Sphygmomanometers: 4 stethoscopes: 4	
	Resuscitation table for the new born	
	Resuscitation tables: 2	
	Suction Machine (electrical/foot): 4	

Department/Unit	Name of equipment	Availability
	Drip stands with double hooks adjustable height: 4	
	Minor operating lights: 4	
	Oxygen supply (cylinders: 4 and oxygen concentrators: 2)	
	Ambu bag and mask Adult and Neonate	
	Angled lamp, torch: 4	
	Autoclave	
	Delivery Kits	
	Vacuum extraction pump	
	Gloves for Placenta removal (Gynaecological gloves)	
	Baby cot /Baby Warmer	
	Dressing drum assorted sizes	
	Jar with 2 cheatle forceps	
	Episiotomy set	
	Penguin sucker	
	Cord clamps	
	Baby weighing scale	
Observation	Beds: 4	
	BP machines	
	Examination bed	
	Screen	
	Drip stand	
	Observation tray	
	Stethoscopes	
Medical records	Shelves	
	Files	
	Cards	
	Office chair and table	
	All necessary medical record form	
Dental room	Endodontic motor NSK: 2	
	Apex locator: 2	
	Water distiller: 1	
	Dental Chair with overhead lamp: 6	
	Air compressor: 2	
	Suction machine: 3	
	Dental X-ray machine: 1	
	Autoclave sterilizer: 1	
	Amalgamator-capsule type: 1	
	Composite curing light- cordless rechargeable LED type: 2	
	X-Ray viewer, portable table top, Mark II: 1	

Department/Unit	Name of equipment	Availability
	Orthopantomography machine: 1	
	Turbine hand piece Kavo super torque, contra angle turbine 640C: 4	
Dental Laboratory	Suspension motor: 1	
	Hand piece-Special for Dental Laboratory: 2	
	Plaster vibrator: 1	
	Denture flask: 3	
	Flask clamp: 1	
	Pacco bath: 1	
	Articulator: 2	
	Spirit lamp: 2	
	Model trimmer: 1	
Wards (Medical, Surgical, Paediatric, Maternity block)	Standard hospital white bed with mattress covered with Mackintosh (Every bed should have at least 2 bedsheets)	
	Patient stretcher	
	Trolley for soiled linen	
	Drip stand: 2	
	Screen four folds: 8	
	Trolleys (different uses)	
	Bed elevator and Back rest: 1	
	Suction Machine foot/Electric: 2	
	Instrument trays (small, Medium, large)	
	Airways Adult: 5 and Children: 5	
	Oxygen Concentrator: 4	
	Examination lamps	
	Tables and chairs	
	Lockers,	
	Nearby toilet with bath room	
Radiology and Imaging	CT Scan Machine	
	MRI	
	Functional x-ray machine	
	Processor machine	
	Cassettes	
	X-Ray films different sizes	
	Dark room hopper	
	Angiographic kits	
	Film Badges	
	HSG. Lot	
	X-Ray illuminator	
	ECHO Cardiogram, ECG machines	
	Ultrasound machine: 4 probes	

Department/Unit	Name of equipment	Availability
	Mammography	
	Chair and table	
	Proctoscopy/Colposcopy	
	Oesophagiogastroduodenoscopy (OGD)	
	Computed Radiography	
Minor Theatre (Casualty)	Sterilizer – electric/kerosene	
	Diathermy machine	
	Suction Machine electric or fast sucker	
	Sphygmomanometer and stethoscope	
	Adult and Paediatric resuscitators	
	Airway adult	
	Airway Neonates	
	Airway infants	
	Anaesthetic Machine	
	Oxygen concentrator	
	Instrument trays (Large: 1, Medium: 1, Small: 1)	
	Dressing drums (Deep-large: 1, Deep-small: 1, Shallow-large: 1, Shallow-small: 1)	
	Drip stands	
	Oxygen Cylinders (Large: 6, Small *portable)	
	X-ray view box /Illuminator	
	Operating theatre light	
Major Operating Theatre	Operating table: 5	
	Patients stretcher complete: 4	
	Wheel chair invalid filing adult size: 2	
	Trolley for soiled linen.	
	Anaesthetic Machine (Boyles) Complete with accessories: 1	
	Operating light	
	Diathermy	
	Wheel chair,	
	Anaesthetic trolley	
	Suction machine (Digital/ Automatic)	
	Laryngoscope set	
	Oxygen cylinders: 4 and Oxygen concentrator: 4	
	E. Tubes (various size)	
	Magill’s forceps: 2	
	Instrument trays (Large:1, Medium:1, Small:1)	
	Set of Trays	
	General set (Laparotomy set: 2)	
	Caesarean section set: 2	
	Dilatation and curettage: 2	
	Relief of retention of urine: 1	

Department/Unit	Name of equipment	Availability
	Limb amputation (emergency)	
	Vacuum extraction set: 1	
	Cutting down tray	
	Tracheostomy tray (Emergency)	
	Dressing drums (Deep-large: 1, Deep-small: 1, Shallow- large: 1, Shallow-small: 1)	
	Dressing Trolley: 1	
	Drip Stand with Double Hooks Adjustable Height: 2	
	Resuscitation trolley	
	Ventilator	
	Defibrillator	
	Chairs	
	X-ray view box/Illuminator	
	Wall clock	
Intensive Care Unit	Special ICU beds: 12	
	Pulse oximeter: 1	
	Cardiac Monitor, Electrocardiograph (ECG)	
	Suction Machine	
	Humidifier temperature	
	Equipment to control patient's temperature	
	Airway access equipment, including bronchoscopy equipment	
	Vascular access equipment	
	Infusion and specialised pumps	
	Alarms for Breathing System Disconnection Ventilator volumes and pressures	
	Oxygen cylinder/ Oxygen concentrator; Piped gas supply failure alarm	
	Sphygmomanometer	
	Ambu bag adult: 1	
	Ventilator	
	Laryngoscope Set: 1	
	Defibrillator: 1	
	Range of End tracheal tubes (3, 5, 6, 7, 8, 8.5 Fr.)	
	Range of Cannulas size (24, 22, 20, 18, 16 G)	
	Intubation tube for Adult (7, 7.5, 8 Fr.)	
	T pieces (breathing circuits: 2)	
	Resuscitation trolley	
ICT equipment (see with ICT section)	Computers	
	External data backup	
	UPS	
	LAN / Internet supply	
Mortuary	Refrigerators	
	Autopsy slab	

Department/Unit	Name of equipment	Availability
	Autopsy set	
	Cupboard	
	Sinks: 2	
	Running water	
	Cleaning section	
	Dead body Trolley	
	PPEs	

7) Recommend antiseptic and disinfectant

Antiseptics	Check
a) Alcohol based *Alcohols (60–90% ethyl, isopropyl or "methylated spirit")* *Chloroxylenol (Para-chloro-metaxylenol) (0.5–3.75%), (e.g., Dettol®)*	
b) Chlorhexidine based *Chlorhexidine gluconate (2–4%) (e.g., Hibitane®, Hibiscrub®, Hibiclens®)* *Chlorhexidine gluconate and cetrimide, (e.g., Savlon®)* *Iodine (3%); Iodophors (7.5–10%) (e.g., Betadine®)* *Acridine derivatives (e.g., gentian or crystal violet)* *Cetrimide (e.g., Cetavlon®)* *Chlorhexidine gluconate and cetrimide in various concentrations (e.g., Savlon)* *Chlorhexidine gluconate (e.g., Hibiscrub, Hibitane)* *Chlorinated lime and boric acid (e.g., Eusol®)*	
Disinfectant	Check
Chlorines compounds (powder or tablets) Calcium hypochlorite (70% available chlorine) Calcium hypochlorite (35% available chlorine) Sodium dichloroisocyanurate (NaDCCc)- (60% available chlorine) Chloramine tablets (1 g of available chlorine per tablet) NaDCC-based tablets (1.5 g of available chlorine per tablet) **Glutaraldehyde 2 – 4%**	

8) Tracer Medicines

No.	Name of Medicine	Traced
1	DPT + HepB/ HiB vaccine for immunization	
2	Artemether / Lumefantrine (ALu) oral	
3	Amoxycillin or Cotrimoxazole syrup	
4	Amoxycillin or Cotrimoxazole oral	
5	Albendazole or Mebendazole oral	
6	Oral Rehydration Salts (Compacted Zinc ORS)	
7	Ergometrine inj. or Oxytocin inj. or Misoprostol oral	
8	Medroxyprogesterone injectable Contraceptive	
9	Dextrose 5% or Sodium Chloride + Dextrose IV inj.	
10	Malaria rapid diagnostic test (MRDT) or Supplies for malaria microscopy	

No.	Name of Medicine	Traced
11	Syringe and needle, disposable	
12	Magnesium Sulphate inj.	
13	Zinc Sulphate tablets	
14	Paracetamol tablets	
15	Benzyl Penicillin inj	
16	Ferrous +Folic Acid Tablets	
17	Metronidazole Tablets	
18	Combined Oral Contraceptives	
19	Catgut Sutures	
20	Nevirapine Oral Solution	
21	Tenofovir 300mg +Lamivudine 300mg +Efavirenz 600mg Tablets	
22	Efavirenz 600mg Tablets	
23	Zidovudine 60mg + Lamivudine 30mg + Nevirapine 50mg Tablets	
24	UNIGOLD HIV 1/2	
25	SD Bioline	
26	FACS Count reagent	
27	DBS	
28	RHZE (Rifampicin 150mg/ Isoniazide 75mg/ Pyrazinamide/ Ethambutol) Tablets	
29	RH (Rifampicin 15mg/ Isoniazide 75mg) Tablets	
30	Sulphadoxine + Pyramethamine Tablets	

9) Checklist for Tracer Medicine in selected Department

Name of Department	Name of Tracer Medicine		Tracer List	Prescribing records			Physical Count	
			Check	Check	Updated	Monthly Consumption	Correct to record	Enough stock
	1							
	2							
	3							
	1							
	2							
	3							
	1							
	2							
	3							
	1							
	2							
	3							
	1							
	2							
	3							

10) Emergency Equipment List on OT

No	Equipment	Availability
1	Mayo Instrument	
2	Diathermy Machine	
3	Anaesthetic Trolley	
4	Bag to Inflate Lungs	
5	Bag and Face Masks (Adult and Paediatric).	
6	Pulse Oximeter – 1	
7	Laryngoscope	
8	Macintosh Blades 1 – 3 (4)	
9	Oxygen Concentrators/Cylinders	
10	Sphygmomanometer 1	
11	Stethoscope 1	
12	Suction Machine (Electrical)	
13	Anaesthetic Machine	
14	Endotracheal Tubes	

11) Client exit interview

Client over age 18 or representative if client under 18

Explain the purpose of this 5-minute interview to the client (or the client's representative in the case of minors) and obtain consent.

Purpose: "We are here to give an External Hospital Performance Assessment for this facility. May I ask you a few questions to know if your visit was satisfactory?"

No.	Question	Responses	Answer										
			1	2	3	4	5	6	7	8	9	10	Total
1	How long did you wait before you were seen by a health worker?	1: Less than 60 minutes 0: 60 minutes or more											
2	Was the waiting time acceptable to you?	1: Yes 0: No											
3	Did the health worker examine you?	1: Yes 0: No											
4	Did the health worker explain about your care, or illness, and about any tests or treatment?	1: Yes 0: No											
5	Did you receive all the prescribed medicines?	1: Yes 0: No											

No.	Question	Responses	Answer										
			1	2	3	4	5	6	7	8	9	10	Total
7	Were the health workers polite and respectful?	1: Yes 0: No											
8	Did you have enough privacy during your visit?	1: Yes 0: No											
9	Did you find the facilities clean and in order?	1: Yes 0: No											
10	Are the fees and charges fair and affordable to you? [Q also applies to CHF/ NHIF members]	1: Yes 0: No											
Total													

12) SOPs for Dispensing

The SOP should contain the following important guides on good dispensing practice and displayed:

No.	Guide	Case No. (Check)																			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	**Review of the prescription** – check patient name, medicines, form, strength and dosage, prescriber's name;																				
2	**Issue of the correct medicine**– check physically against the prescription;																				
3	**Correct labelling** – date of dispensing, generic name of medicine, strength, no. of units, directions for use (dosage frequency and duration), name of patient and facility.																				
4	**Instruction of the patient on correct use**– how to use each medicine (e.g. "with food"), dosage, duration, possible side effects, special storage requirements																				

13) Protocols for OT (Refer WHO 2007), Best Practice Protocols Clinical Procedures Safety

Category	Question	Check
1. Ethics-Patient Consent	Before performing a procedure, it is important to receive consent from the patient:	
	- Ask permission to make an examination	
	- Explain what you intend to do before doing it	
	- Ask the patient if he/she has questions and answer them	
	- Check that the patient has understood	
	- Obtain permission to proceed	
	- Be mindful of the comfort and privacy of others.	
2. Record keeping	Admission note/preoperative note	
	Operating room records: usually includes:	
	- Patient identity	
	- Procedure performed - Persons involved	
	- Complications.	
	The operative note	
	Postoperative notes can be organized in the “SOAP” format: usually includes:	
	- Subjective How the patient feels	
	- Objective Findings on physical examination, vital signs and laboratory results	
	- Assessment What the practitioner thinks	
	- Plan Management plan; this may also include directives which can be written in a specific location as “orders”	
	Discharge note, record (usually includes)	
	- Admitting and definitive diagnoses	
	- Summary of patient’s course in hospital	
	- Instructions about further management as an outpatient, including any medication and the length of administration and planned follow-up	
3. Operating Room (OR)	The operating theatre is a room specifically for use by the anaesthesia and surgical teams and must not be used for other purposes. Both rooms require	
	• Clear theatre zones	
	• Good lighting and ventilation	
	•Dedicated equipment for procedures	
	•Equipment to monitor patients, as required for the procedure	
	•Drugs and other consumables for routine and emergency use	
	•Ensure that procedures are established for the OR correct use of the OR and all staff is trained to follow them:	
	•Keep to a minimum the number of people allowed to enter the OR, especially after an operation has started.	
	•Keep OR uncluttered and easy to clean	
	•Between cases, clean and disinfect the table and instrument surfaces	
	• At the end of each day, clean the OR: start at the top and continue to the floor, including all furniture, overhead equipment and lights, use a liquid disinfectant at a dilution recommended by the manufacturer	
	• Sterilize all surgical instruments and supplies after use and store them protected and ready for the next use Leave the OR ready for use in case of Emergency	

Category	Question	Check
4. Scrubbing and gowning	Before each operation, all members of the surgical team – that is, those who will touch the sterile surgical field, surgical instruments or the wound – should scrub their hands and arms to the elbows.	
	• Every hospital should develop a written procedure for scrubbing that specifies the length and type of scrub to be undertaken.	
	• It is usual that the first scrub of the day is longer (minimum 5 minutes) than any subsequent scrubs between consecutive clean operations (minimum 3 minutes).	
5. Infection Prevention and Control	Hand washing, the use of barrier protection such as gloves and aprons, the safe handling and disposal of "sharps" and medical waste and proper disinfection, cleaning and sterilization are all a part of creating a safe hospital.	
	Key Points	
	1. A safe injection does not harm the recipient, does not expose the provider to any avoidable risk and does not result in any waste that is dangerous for other people	
	2. Use a sterile syringe and needle for each injection and to reconstitute each unit of medication	
	3. Ideally, use new, quality controlled disposable syringes and needles	
	4. If single-use syringes and needles are unavailable, use equipment designed for steam sterilization	
	5. Prepare each injection in a clean, designated area where blood or body fluid contamination is unlikely	
	6. Use single-dose vials rather than multi-dose vials	
	7. If multi-dose vials must be used, always pierce the septum with a sterile needle; avoid leaving a needle in place in the stopper of the vial. Once opened, store multi-dose vials in a refrigerator.	
6. Waste management in healthcare facility	It is essential for the hospital to have protocols to deal with biological waste and contaminated materials. All staff must be familiar with them and follow them.	
	• All biological waste must be carefully stored and disposed of safely.	
	• Contaminated materials such as blood bags, dirty dressings and disposable needles are potentially hazardous and must be treated accordingly.	
	• If biological waste and contaminated materials are not disposed of properly, staff and members of the community could be exposed to infectious material and become infected.	
	• Disposal of bio hazardous materials is time consuming and expensive, so it is important to separate non-contaminated material such as waste paper, packaging and non-sterile but not biologically contaminated materials. (Only 15% to 20% of medical wastes are considered infectious.)	
	• Make separate disposal containers available where waste is created so that staff can sort the waste as it is being discarded. A three-colour coding system with black for none infectious waste, red or yellow for infectious and yellow for sharps is recommended. (continued next page)	
7. Check List Prior to inducing anaesthesia	An experienced and trained assistant is available to help you with induction.	
	You have the correct patient scheduled for the correct operation on the correct side.	
	The patient has been properly prepared for the operation and has had no food or drink for the appropriate period.	

Category	Question	Check
	The patient's progress through the hospital up to this moment and then check that your actions will be the right ones.	
	Adequate intravenous access is obtained	
	The patient is lying on a table that can be rapidly tilted into a head-down position in case of sudden hypotension or vomiting.	
8. Postoperative management	Look out for the following in recovery:	
	• Airway obstruction	
	• Hypoxia	
	• Haemorrhage: internal or external • Hypotension and/or hypertension • Postoperative pain	
	• Shivering, hypothermia	
	• Vomiting, aspiration	
	• Falling on the floor	
	• Residual narcosis	
9. Postoperative pain relief	Pain Management and Techniques	
	• Effective analgesia is an essential part of post-operative management.	
	• Important injectable drugs for pain are the opiate analgesics. Non-steroidal anti-inflammatory drugs (NSAIDs), such as diclofenac (1 mg/kg) and ibuprofen can also be given orally and rectally, as can paracetamol (15 mg/kg).	
	• There are three situations where an opiate might be given:	
	- Preoperatively	
	- Intraoperatively	
	- Postoperatively	
	• Opiate premedication is rarely indicated, although an injured patient in pain may have been given an opiate before coming to the operating room.	
	• Opiates given pre-oriental operatively have important effects in the post-operative period since there may be delayed recovery and respiratory depression, even necessitating mechanical ventilation.	
	First priority is establishment or maintenance of airway patency.	
10. Airway Management	1. Talk to the patient A patient who can speak clearly must have a clear airway. Airway obstruction by the tongue in the unconscious patient is often a problem. The unconscious patient may require assistance with airway and/or ventilation. If you suspect a head, neck or chest injury, protect the cervical spine during endotracheal intubation.	
	2. Give oxygen Give oxygen, if available, via self-inflating bag or mask.	
	3. Assess the airway- Signs of airway obstruction include:	
	- Snoring or gurgling	
	- Stridor or abnormal breath sounds	
	- Agitation (hypoxia)	
	- Using the accessory muscles of ventilation/paradoxical chest movements	
	- Cyanosis.	
	Be alert for foreign bodies. Intravenous sedation is absolutely contraindicated in this situation.	
	4. Consider the need for advanced airway management	
	5. Indications for advanced airway management techniques include:	
	- Persisting airway obstruction	

Category	Question	Check
	- Penetrating neck trauma with haematoma (expanding)	
	- Apnea	
	- Hypoxia	
	- Severe head injury	
	- Chest trauma	
	- Maxillofacial injury	
	- Airway obstruction requires urgent treatment.	
11. Transportation of critically ill patients	Transporting patients is risky. It requires good communication, planning and appropriate staffing.	
	• Any patient who requires transportation must be effectively stabilized before departure.	
	• As a general principle, patients should be transported only if they are going to a facility that can provide a higher level of care.	
	• Planning and preparation include consideration of:	
	- Type of transport (car, lorry, boat, etc.)	
	- Personnel to accompany the patient	
	- Equipment and supplies required enroot for routine and emergency treatment	
	- Potential complications	
	- Monitoring and final packaging of the patient.	
	• Effective communication is essential with:	
	- the receiving centre	
	- The transport service	
	- Escorting personnel	
	- The patient and relatives.	

14) Essential Post-mortem/autopsy Equipment

Name of Equipment	Availability
Operating scissors	
Dissecting scissors	
Dissecting forceps	
Bone-cutting forceps	
Saw	
Suture needles	
Probes	
Retractors	
Metal mallet	
Rib shears	
Knives	
Operating scalpel	

Annex A-1. Important guidelines, manuals and documents for ISS and HPA

No.	Name of Guideline / Manual / Document
1	Standard treatment guidelines and essential medicines list
2	IPC Guidelines
3	Basic Nursing procedure manual
4	SOP for various specialized areas (laboratory, surgery, labour ward, Radiology unit, laundry, Central Sterile Supply Department (CSSD))
5	Professional code of ethics
6	List of essential equipment and supplies for carrying out nursing procedures
7	List of emergency procedures
8	Guidelines on complaints procedures
9	Tanzania Quality Improvement Framework
10	Implementation Guidelines for 5S-KAIZEN-TQM Approaches in Tanzania
11	QI Package for HIV care and treatment
12	Comprehensive Emergency Obstetric and New Born Care (CEmONC) guidelines
13	Emergency Triaging of Acute (ETAT)
14	HIV care and treatment guidelines
15	TB and leprosy guidelines (both adults and children)
16	Malaria treatment guidelines
17	National dispensing formulary guidelines
18	Health policy
19	Sexual Transmitted Infection (STI) guidelines
20	Non-communicable disease guidelines
21	National guidelines for health laboratory
22	Health facility planning guidelines
23	Maternal and perinatal death surveillance and response guidelines
24	National Family planning guidelines
25	Focused Antenatal care (FANC) guidelines
26	Neonatal resuscitation
27	Emergency and preparedness and response guidelines
28	Disease surveillance and response guidelines
29	Lifesaving skills
30	e-MTCT –Elimination of mother to child transmission

Annex A-2. Key Performance Indicators
Basic information and data needed for KPI calculation

No.	Basic Information need for KPI calculation	Unit	Remarks
1	Total number of days in the quarter	Day	
2	Total number of OPD days in the quarter	Day	Total number of days – number of Sunday in the quarter
3	Total Population (regional population)	Person	Last year
4	Number of Beds	Bed	Available beds
5	Number of Doctors	Person	Specialists, MO, AMO and CO
6	Number of the surgeons	Person	
7	Number of Nurses	Person	NO, ANO and Nurse
8	Number of Nurses currently in duty station	Person	
9	Total number of Admission	Person	
10	Total number of discharge	Person	
11	Total number of in-patients' days	Day	
12	Total number of out-patients	Person	
13	Total number of Major Surgery	Case	
14	Total number of Minor Surgery	Case	
15	Total number of Deliveries	Case	At the hospital
16	Total number of Caesarean Section	Case	At the hospital
17	Total number of under 5 admitted	Person	
18	Total number of infected neonates	Person	At the hospital
19	Total number of live babies delivered	Case	At the hospital
20	Total number of hospital deaths	Case	At the hospital
21	Total number of Maternal deaths	Case	At the hospital
22	Total number of under 5 deaths	Case	At the hospital
23	Total No of stock out days from tracer medicine &Supplies	Day	10 items (unit will be days/item)
24	Number of written complaints received and acted upon	Case	
25	Number of RRHMT meetings		
26	Number of Hospital Board Meetings		
27	Number of OPD& IPD patients exempted from payment	Case	the number of exemption form issued
28	Total income	TZS	
29	Total amount of allocated for procurement from MSD	TZS	
30	Total cash revenue collection	TZS	
31	Total cost sharing revenue	TZS	
32	Total NHF revenue collection	TZS	
33	Total amount of Out-of-Pocket collection	TZS	
34	Total health services revenue	TZS	
35	Total health services expense	TZS	
36	Total expenditure	TZS	
37	Food service cost	TZS	
38	Total amount spent on repair and maintenance	TZS	

No.	Basic Information need for KPI calculation	Unit	Remarks
39	Total amount of cost of purchased for medicine and supplies/	TZS	
40	Total received referral cases	Case	the number of referral forms
41	Total sent referral cases to the upper level	Case	the number of referral forms
42	Total feedback sent to the lower level	Case	the number of feedback forms

Key Performance Indicators

No.	KPIs	Unit	Calculation formula
KPIs for Hospital Efficiency and Effectiveness			
1	Medicine stock out days of tracer medicine and supplies	Day	Total No. of stock out days from tracer medicine & Supplies (unit will be days/item)
2	% neonatal infection to babies delivered in hospital	%	Total No. of infected neonates ---------- × 100 Total No. of live babies delivered
3	% Maternal deaths	%	Total No. of Maternal deaths ---------- ×100 Total No. of deliveries
4	% of under 5 deaths	%	Total No. of under 5 deaths ---------- ×100 Total No. of under 5 admitted
5	% C/section	%	Total No. of C/Section ---------- ×100 Total No. of deliveries
6	Number of feedback complaints received	case	Number of written complaints received and acted upon
7	Average number of In-patients per day	Person	Total No. of in-patients ---------- Total No. of days
8	Average number of Out-patients per day	Person	Total No. of out-patients ---------- Total No. of OPD days
9	Bed occupancy rate	%	Average number of in-patients ---------- ×100 Total number of beds
10	Average of length of stay	Day	Total number of in-patients' days ---------- （Total No of admission + Total No. of discharge）÷2
11	Average Number of Out-patients per day/doctor	Person	(Average No. of OPD/day) ---------- Number of Doctors
12	Average Number of in-patients day /Nurses	Person	(Average in- patients/day) ---------- Number of Nurses
13	Average Number of in- Patients day /Nurses currently in duty station	Person	(Average in- patients/day) ---------- Number of Nurses currently in duty station
14	Average number of Major Surgeries /Surgeon	Case	Total number of major surgery ---------- Number of Surgeon
15	% of Minor Surgery in total surgery	%	Total No. of Minor Surgery ---------- ×100 (Total No. of minor + major surgeries)

No.	KPIs	Unit	Calculation formula
KPIs for Hospital Governance and Management			
16	Number of RRHMT meetings		No. of meetings held in the quarter
17	Number of Hospital Board Meetings		No. of meetings held in the quarter
KPIs for Finances			
18	% of OPD &IPD Exemption	%	No of OPD+IPD patients exempted from payment ---------- ×100 Total No. of OPD+ IPD
19	Average NHF revenue collection/ day	TZS	Total NHF revenue collection ---------- Total days in the quarter
20	Average cash revenue collection/ day	TZS	Total cash revenue collection ---------- Total days in the quarter
21	% of cost sharing in total income	%	Total cost sharing revenue ---------- ×100 Total income
22	% of health services expense to health services revenue	%	Total Health services expense ---------- ×100 Total health services revenue
23	% of current expense to current income in 90 days	%	Total expense ---------- ×100 Total income
24	Food service costs per in-patient per day	TZS	Food service costs ---------- ×100 Total number of In-patients
25	% of amount spent in repair and maintenance expense in Total recurring expenses	%	Total amount spent on repair and maintenance ---------- ×100 Total recurring expenditure
26	% spent on procurement of medicine and supplies from NHIF	%	Total amount of cost of purchase for medicine and supplies ---------- ×100 Total amount of NHIF collection
27	% spent on procurement of medicine and supplies from Out-of-Pocket collection	%	Total amount of cost of purchase for medicine and supplies ---------- ×100 Total amount of Out-of-Pocket collection
28	% spent on procurement of medicine and supplies from MSD	%	Total amount of cost of purchase for medicine and supplies ---------- ×100 Total amount of allocated for procurement from MSD
KPIs for Referral system			
29	% of referrals received	%	Total received referral cases (ER, OPD IPD) ---------- ×100 (Total No. of OPD and Total No. of admission)
30	% of referred cases to the upper level	%	Total sent referral cases to the upper level (ER, OPD IPD) ----------×100 Total number referral received
31	% of feedback sent to the lower level	%	Total feedback sent to the lower level (ER, OPD IPD) ---------- ×100 Total number patients discharged

Annex B. M&E tools for 5S-KAIZEN-TQM activities

Annex B-1: Interview sheet for QIU/QIT: "Basic hospital information"

This is the tool to correct the basic information of QI implementation structure and capacity of the hospital. This format can be used by both RRHMT and RHMT.

Interview sheet for QIU/QIT (1/2): "Basic hospital information"

(Hand over the form and request HMT to fill in the form)

Name of the hospital					**Date**	
Director/ Medial Officer In-charge E-mail	**Name**		**Phone 1**			
			Phone 2			
Matron / Patron E-mail	**Name**		**Phone 1**			
			Phone 2			
Hospital Secretary E-mail	**Name**		**Phone 1**			
			Phone 2			
QIU Head / QIT Chair-person E-mail	**Name**		**Phone 1**			
			Phone 2			
Total bed capacity						
Total number of depart-ments			**Total number of sections**			
Number of hospital staff		**Total number of doctors**		**Total number of technicians**		
		Total number of nurses		**Total number of Administration staff**		

<table>
<tr><td colspan="2">Number of Hospital Management Team members</td><td colspan="4"></td></tr>
<tr><td colspan="2">Establishment of Hospital Advisory board (HAB)</td><td colspan="2">Established / Not established
(Established year and month: _____)</td><td>Number of HAB members</td><td></td></tr>
<tr><td>1</td><td>Establishment of QIU or QIT</td><td colspan="2">Established / Not established
(Established year and month: _____)</td><td>Number of QIU/QIT members</td><td></td></tr>
<tr><td>2</td><td>Composition of QIU/ QIT</td><td colspan="4">
<table>
<tr><td>Doctor</td><td>A-M/O</td><td>C/O</td><td>Nurse</td><td>Admin.</td><td>Lab. Tech.</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Pharmacist</td><td></td><td></td><td></td><td></td><td></td></tr>
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Number of <u>Permanent (full-time) staff</u> working in QIU: _____
</td></tr>
<tr><td>3</td><td>Establishment of QIU/QIT office</td><td colspan="4">• The office is allocated and adequately equipped for QIU/QIT (i.e. chairs, tables, computer, shelves etc.)
• The office is partially equipped
• Not allocated</td></tr>
<tr><td colspan="2">Current QI programs at the hospital</td><td colspan="4">
<table>
<tr><td>Name of QI programs</td><td>Supported by (Donors)</td><td>Sections that are practicing the QI programs</td></tr>
<tr><td></td><td></td><td></td></tr>
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Challenges that HMT and QIU/ QIT are facing in 5S-KAI-ZEN-TQM implementation	• • • • • • •	

Annex B-2: Interview sheet for QIU/QIT: Current QIU/QIT status and activities

This is the tool to measure the functionality of Quality Improvement Unit (QIU) or Team (QIT) and Work Improvement Teams (WITs). This is importance information how QIU/QIT and WIT are performing. This format can be used by both RHMT and MoHCDGEC.

Current QIU/QIT status and activities

(Ask QIU/QIT during the interview with QIU/QIT, and fill in the form)

(*) IS; Implementation Structure, PL; Planning, IM; Information Management, TF; Training and Follow-up

SQ#	Items	Brief explanation	Answer and Score			(*)
1	**Establishment of QIU/QIT**	Ask about whether QIU/QIT is established with fulltime / part-time staff	**2**	Established with fulltime staff		IS
			1	Established with part-time staff		
			0	Not established		
2	**Composition of QIU/QIT**	Ask about whether QIU/QIT is multidisciplinary members	**2**	Established with fulltime and multidisciplinary members		IS
			1	Established with part-time and multidisciplinary members		
			0	Established but not with multidisciplinary members		
3	**Establishment of QIU/QIT office**	Ask about whether QIU/QIT office is established with necessary equipment	**2**	Established with necessary equipment		IS
			1	Established with necessary equipment		
			0	Not established		
4	**Allocation of budget for QI activities**	Ask whether the hospital allocates specific budget for QI activities	**2**	Allocated in: CHOP/Other plans		IS
			1	Not allocated but disbursed from other budget plans sometimes		
			0	Not allocated		
			If the answer is "1" or "0", ask how QI activities in the hospital are implemented?			
5	**Mechanism for increasing hospital revenue**	Ask about whether there is any mechanism for increasing hospital revenue by proper application of 5S-KAIZEN	**2**	Mechanism in place and well followed with evidences		IS
			1	Mechanism in place but not followed		
			0	No mechanism		
			If the answer is "2" or "1", describe how and what the mechanism is:			
6	**Declaration of commencement of 5S-KAIZEN**	Ask whether MOI/C and other executive HMT members declared commencement of 5S-KAIZEN	**2**	Declared with written official documents		IS
			1	Declared with no written official document		
			0	Not declared		
7	**Roles and responsibilities of QIU/QIT**	Ask whether QIU/QIT has own roles and responsibilities. The roles and responsibilities to be written and shared with all hospital staff	**2**	Developed, written and shared with all hospital staff		IS
			1	Developed and written but known by limited personal		
			0	Not developed		

SQ#	Items	Brief explanation	Answer and Score			(*)
8	**QIU/QIT meeting**	Ask about the frequency of QIU/QIT internal meetings	**2**	Conducted regularly		PL
			1	Conducted irregularly		
			0	Not conducted		
			Frequency: Weekly/Monthly/Quarterly/Other: ……			
			The latest meeting: Month …… Year ……			
9		Ask to show the evidences on QIU/QIT meeting (ex. minutes / schedule / attendance list etc.)	**2**	Every evidence is available		IM
			1	Some of evidence are missing		
			0	Not available		
10	**QIU/QIT meeting <u>with HMT</u>**	Ask about frequency of the meetings between QIU/QIT and HMT	**2**	Conducted regularly		PL
			1	Conducted irregularly		
			0	Not conducted		
			Frequency: Weekly/Monthly/Quarterly/Other: ……			
			The latest meeting: Month …… Year ……			
11		Ask to show the evidences on QIU/QIT meeting with HMT (ex. Minutes, schedule, attendance etc.)	**2**	Every evidence is available		IM
			1	Some of evidence are missing		
			0	Not available		
12	**QIU/QIT meeting <u>with WITs</u>**	Ask about frequency of the meetings between QIU/QIT and WITs	**2**	Conducted regularly		PL
			1	Conducted irregularly		
			0	Not conducted		
			Frequency: Weekly/Monthly/Quarterly/Other: ……			
			The latest meeting: Month …… Year ……			
13		Ask to show the evidences on QIU/QIT meeting with WITs (ex. Minutes, schedule, attendance etc.)	**2**	Every evidence is available		IM
			1	Some of evidence are missing		
			0	Not available		
14	**Trained staff on 5S and KAI-ZEN**	Ask about number of staff trained on 5S	**3**	100% of the staff is trained on 5S		TF
			2	Between 70% to 99% of the staff is trained on 5S		
			1	Between 40% to 69% of the staff is trained on 5S		
			0	Less than 39% of the staff is trained on 5S		
15		Ask about number of staff trained on KAIZEN	**3**	100% of the staff is trained on KAIZEN		TF
			2	Between 70% to 99% of the staff is trained on KAIZEN		
			1	Between 40% to 69% of the staff is trained on KAIZEN		
			0	Less than 39% of the staff is trained on KAIZEN		

SQ#	Items	Brief explanation	Answer and Score			(*)
		(Details)	Total number of staff in the hospital: …… Total number of trained staff on 5S: …… (……%) Total number of trained staff on KAIZEN: …… (……%)			
16	**Number of sections practicing 5S and KAIZEN**	Ask about number of areas practicing 5S	**3**	100% of sections is practicing 5S		TF
			2	Between 70% to 99% of sections is practicing 5S		
			1	Between 40% to 69% of sections is practicing 5S		
			0	Less than 39% of sections is practicing 5S		
17		Ask about number of areas practicing KAIZEN	**3**	100% of sections is practicing KAIZEN		TF
			2	Between 70% to 99% of sections is practicing KAIZEN		
			1	Between 40% to 69% of sections is practicing KAIZEN		
			0	Less than 39% of sections is practicing KAIZEN		
		(Details)	Total number of departments in the hospital: …… Total number of sections in the hospital: …… Number of sections practicing 5S: …… (……%) Number of sections practicing KAIZEN: …… (……%)			
18	**Establishment of WIT**	Ask about establishment of WITs at section level	**3**	All areas have WITs (all areas)		IS
			2	Between 70% to 99% of sections have WITs		
			1	Between 40% to 69% of sections have WITs		
			0	Less than 39% of sections have WITs		
			Total number of WIT in the hospital: …… (……%)			
19	**Roles and responsibilities of WIT**	Ask whether WITs have own roles and responsibilities. These are supposed to be written and shared with all staff	**2**	Developed, written and shared with all hospital staff		IS
			1	Developed and written but known by limited personal		
			0	Not developed		
20	**Internal monitoring for 5S and KAIZEN**	Ask about frequency and tools of internal **monitoring** by QIU/ QIT to WITs	**2**	Regularly conducted		PL
			1	Irregularly conducted		
			0	Not conducted		
			Frequency: Weekly/Monthly/ Quarterly/Other: …… The latest internal monitoring: Month ……Year …… Availability of tool(s) for internal evaluation: Available / Not available			
21		Ask to show documents related with internal monitoring (ex. schedule, tool(s), monitoring results, pictures	**2**	All documents are well documented, kept in QIU/QIT file, and shared with HMT and hospital staff		IM
			1	Some of documents are documented and kept in QIU/QIT file but some are missing		
			0	Not documented		

SQ#	Items	Brief explanation	Answer and Score			(*)
22	**Internal evaluation for 5S and KAIZEN**	Ask about frequency and tools of internal **evaluation** by QIU/QIT to WITs	**2**	Regularly conducted		PL
			1	Irregularly conducted		
			0	Not conducted		
			Frequency: Weekly/ Monthly/Quarterly/Other: …… The latest internal evaluation: Month ……Year …… Availability of tool(s) for internal evaluation: Available/Not available			
23		Ask to show documents related with internal evaluation (ex. schedule, tool(s), monitoring results, pictures	**2**	All documents are well documented, kept in QIU/QIT file, and shared with HMT and hospital staff		IM
			1	Some of documents are documented and kept in QIU/QIT file but some are missing		
			0	Not documented		
24	**Action plan for QIU/QIT**	Ask whether QIU/QIT develops, followed and updated action plan for QI activities	**2**	Develop, followed and updated		PL
			1	Developed but not updated		
			0	Not developed		
25		Ask whether the plan incorporates 5S-KAIZEN activities	**2**	Incorporated 5S-KAIZEN into QIU/QIT action plan		PL
			1	Plan for 5S-KAIZEN developed but not incorporated into QIU/QIT action plan		
			0	Not developed		
26	**In-house recognition / awarding events**	Ask about any in-house recognition events and awarding events to 5S-KAIZEN implementation in the hospital	**2**	Conducted regularly as planned		PL
			1	Irregularly conducted		
			0	Not conducted		
			The latest event: Month ……Year …… Any details:			
27	**Records on QI activities**	Ask about keeping records on QI activities in the hospital	**2**	All are kept in “QIU/QIT file”		IM
			1	Some are kept in “QIT file”		
			0	No recorded		
28	**Annual report on QI programs and activities**	Ask about a way of compilation of annual report on QI in the hospital.	**2**	Developed and submitted to HMT		IM
			1	Developed but not submitted to HMT		
			0	Not developed		
29	**Recording and sharing good practices of 5S-KAIZEN**	Ask about a way of recording and sharing good practices of 5S and KAIZEN activities	**2**	Good practices are recorded and shared with all hospital staff		IM
			1	Good practices are recorded but shared with limited personnel		
			0	Not recorded		

Annex B-3: Monitoring and Evaluation Sheet for Implementation of 5S-KAIZEN Activity

This is the tool to measure the level of 5S and KAIZEN implementation at department/section.
This format can be used by RRHMT and QIU/QIT for monitoring purpose and can be used by both RHMT and MoHCDGEC for evaluation purposes.

Monitoring and Evaluation Sheet for Implementation of 5S-KAIZEN Activity

Name of evaluator	1.	**Section visited**	#1.
	2.		#2.
	3.		#3.
	4.		#4.
	5.		#5.

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
Leadership	**1**	Ask/observe about knowledge, awareness on 5S among managers and health workers	1. Managers and staff are not aware of 5S-KAIZEN activity. 2. Managers and staff are aware of 5S activities but not able to explain about 5S-KAIZEN activities accordingly. 3. Managers and staff are able to explain about 5S-KAIZEN activities accordingly but not able to explain the purpose of 5S-KAIZEN activity. 4. Managers and staff are able to explain about 5S activities with the purposes of 5S-KAIZEN activity. 5. All managers and staff are able to explain the purpose of 5S-KAIZEN activity and there is evidence of their willingness to practice.					
	2	Ask/observe about in-charge of department/section fosters/ promotes the implementation of 5S-KAIZEN activities in department/section	1. There is no departmental/sectional 5S-KAIZEN orientation program for the staff. 2. There is departmental/sectional 5S-KAIZEN orientation program for the staff but no evidences of its implementation. 3. There is departmental/sectional 5S-KAIZEN orientation program for the staff with the evidence of its implementation. 4. The in-charge organizes 5S-KAIZEN activities in the department/section and its records are well managed. 5. The in-charge negotiates with QIT or upper management/committee to obtain any resources for implementation of 5S-KAIZEN activities, with evidences.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
Sorting	**3**	Ask/observe about items are categorized according to sorting categories, and unnecessary items remove d from working place; including walls, notice boards, drawers, cabinets and shelves etc., with an inventory	1. No sorting activities done. 2. Items are categorized but unnecessary items remain in the section/department. 3. Item are categorized, unnecessary items removed, and dumped in the hospital yard. 4. Items are well categorized; unnecessary items are sent to unnecessary item store without an inventory. 5. Items are well categorized; unnecessary items are sent to unnecessary item store with an inventory.					
	4	Ask/observe about storage/place for unnecessary items is identified at section and unnecessary items are grouped accordingly.	1. The storage/place is not identified. 2. The storage/place is identified but unnecessary items are not kept in the storage/place. 3. The storage/place is identified but the items are not grouped accordingly. 4. The storage/place is identified and the items are grouped accordingly or retuned to main store/ workshop without inventory 5. The storage/place is identified and the items are grouped accordingly or retuned to main store/ workshop with inventory					
Setting	**5**	Ask/observe about necessary items are arranged according to the current work flow for the efficiency of the work	1. Necessary items are not arranged. 2. Necessary items are arranged without consideration of work efficiency. 3. Necessary items are arranged with consideration of work efficiency. 4. Necessary items are arranged with consideration of work efficiency and mistake proofing. 5. Necessary items are arranged with consideration of work efficiency, mistake proofing and safety.					
	6	Ask/observe about "Can see, Can take out and Can return philosophy"/ 3F (Fixed items, Fixed place, and Fixed numbers) principle/ FEFO (First Expire First Out) are applied for arrangement of the items for considering the productivity and safety	1. Necessary items are not well arranged. 2. Necessary items are arranged without considering work process. 3. Necessary items are arranged based on the beautification. 4. Necessary items are arranged without 3F, FEFO etc. 5. Necessary items are well arranged with 3F, FEFO etc. based on the productivity and safety.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
	7	Ask/observe about knowledge on effective use of tools for 5S and observe its utilization such as Labels, Zoning, X-Y Axis, Color Coding, Numbering etc.	1. No tools are used for 5S activities. 2. Have knowledge on tools for 5S but not applied. 3. Items are arranged using tools for 5S but the tools are not effectively used. 4. Items are well arranged using tools for 5S but agreed set of rules for tools usage are not set and shared. 5. Items are well arranged using tools for 5S and agreed set of rules for tools usage are set and shared.					
Shining	**8**	Observe and ask about all work-place including toilets, sluice room, changing room etc. are clean and tidy	1. Most of areas are not cleaned and tidy. 2. Few areas are cleaned and tidy. 3. Most of areas are cleaned and tidy. 4. All areas are cleaned and tidy. 5. All areas are cleaned and tidy with displayed cleaning schedule.					
	9	Ask/observe about waste man-agement strategy is implemented according to the national IPC standards	1. Staffs do not have basic knowledge on proper waste management and poor waste management is observed. 2. Staffs have weak knowledge on proper waste management and poor waste management is observed. 3. Staffs have basic knowledge on proper waste management but poor waste management is observed 4. Waste management is implemented based on the own standards. 5. Waste management is implemented properly according to the national IPC standards.					
	10	Ask/observe about machines, equipment, tools and furniture are maintained and in working order	1. Many machines/equipment/tools/furniture are not functioning. 2. Few machines/equipment/tools/furniture are not functioning. 3. Machines/equipment/tools/furniture are maintained and functioning by observation. 4. Machines/equipment/tools/furniture are well maintained with maintenance records but PPM schedule is not available. 5. Machines/equipment/tools/furniture are well maintained with both of maintenance records and PPM schedule.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
Standard-ization	**11**	Ask/observe about S1-S3 activities are regularly implemented in the same manner and monitored at the department /section.	1. S1 to S3 activities is not standardized. 2. No checklist developed for monitoring of S1 to S3 activities. 3. The checklist available but not used. 4. Checklist is used for monitoring of S1-S3 activities. 5. Good results of monitoring of S1-S3 activities is confirmed.					
	12	Ask/observe about in-house rules for S1-S3 activities are developed and shared by everyone in the section.	1. Rules for S1-S3 activities are not developed. 2. Rules for S1-S3 activities are partially developed. 3. Rules for S1-S3 activities are fully developed but not followed. 4. Rules for S1-S3 activities are fully developed and followed but not shared. 5. Rules for S1-S3 activities are fully developed, followed, and shared evidenced by observation.					
	13	Ask/observe about various procedures are carried out according to the given standards.	1. There is no SOP. 2. Some SOPs are developed but not applied/practiced. 3. Some SOPs are developed and applied/practiced. 4. All necessary SOPs are developed but some SOPs are not applied/practiced yet. 5. All necessary SOPs are developed, applied/practiced by all staff in the section.					
	14	Ask/observe about disposal and maintenance procedure/mechanism is in place and followed	1. No existing disposal and maintenance procedure/mechanism. 2. Disposal and maintenance procedure/mechanism is on the process of development. 3. Disposal and maintenance procedure/mechanism is in place but not followed. 4. Disposal and maintenance procedure/mechanism is in place and followed but not properly recorded. 6. Disposal and maintenance procedure/mechanism is in place, followed and well recorded.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
Sustaining	**15**	Ask/observe about section training and continuous orientation on 5S-KAIZEN-TQM are conducted for all categories of healthcare worker in the section	1. No evidence of section training and orientation on 5S-KAIZEN-TQM Approach. 2. Section training and orientation are planed but not conducted. 3. Section training and orientation on 5S-KAIZEN-TQM Approach is occasionally conducted and well recorded. 4. Section training and orientation on 5S-KAIZEN-TQM Approach is regularly conducted and well recorded. 5. Section training and orientation on 5S-KAIZEN-TQM Approach is regularly conducted and well recorded and teaching materials are updated with evidences.					
Sustain	**16**	Ask/observe about any mechanism in place, for motivating staff in implementation of 5S-KAIZEN activities	1. No mechanism for staff motivation in place 2. Mechanism for staff motivation is in place but not implemented 3. Mechanism for staff motivation is in place but irregularly implemented 4. Mechanism for staff motivation is in place and regularly implemented but not documented 5. Mechanism for staff motivation is in place and regularly implemented and documented					
	17	Ask/observe about photographic evidences of before and after 5S implementation are in place	1. No pictorial records. 2. Pictorial records are there but the pictures are kept by QIT hence difficult to compare the situation before and after 5S-KAIZEN activities. 3. Pictorial records are displayed but not-periodically updated. 4. Pictorial records are displayed, periodically updated but not recorded in proper manner. 5. Pictorial records are displayed, periodically updated and recorded in proper manner.					
Productivity	**18**	Ask/observe about identification and proper utilization of the health resources (HRH, finance, commodities and equipment) by using 5S-KAIZEN	1. Necessary resources are not identified 2. Necessary resources are identified but not effectively utilized 3. Partial utilization of the health resources 4. Effective utilization of the health resources with no evidence 5. Effective utilization of the health resources with evidence					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
	19	Ask/observe about reviewing the processes or health service delivery and adopt new ideas to improve the productivity of the section/department	1. No consideration of reviewing processes 2. Reviewing process is done but no action taken. 3. Reviewing process is done and actions taken with no evidence 4. Reviewing process is done and actions taken with evidence 5. Processes are reviewed with Value Stream Mapping and improved for improvement of productivity, safety and mistake proofing.					
	20	Ask/observe about practice of 5S KAIZEN concept is well utilized to increase the productivity of section	1. No application of 5S-KAIZEN activities. 2. 5S-KAIZEN have been practiced without consideration of productivity. 3. Some useful tools such as “labeling”, “zoning”, “numbering” are applied for improvement of productivity. 4. Visual control method is well applied for improvement of productivity but not well followed by staff. 5. Visual control method is well applied for improvement of productivity and rules are well followed by staff in the section.					
Quality	**21**	Ask/observe about documentation and utilization of the data and information to improve the quality of service	1. Information not shared at all, no plan for transferring and disseminating information, no notice board, no dissemination of the information to the subordinate. 2. Plan to transfer information to sub ordinate is known, notice board is available but utilize. 3. Planning mechanism for sharing information in place, but followed irregularly. 4. Plan mechanism for sharing information followed but not documented for an external customer. 5. There is good mechanism of sharing information to internal and external client, plan followed and information well delivered.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
	22	Ask/observe about fewer rejects, fewer wastage (MURI, MURA, MUDA), through 5S-KAIZEN process **Definition of MURI, MURA and MURA: Refer to "Implementation Guideline for 5S-KAIZEN-TQM Approaches"*	1. No evidence of measure taken to reduce waste or rework i.e. .no visual control for stock management and no standardize checklist. 2. Evidence to reduce waste, rework, present visual control applied but not clearly understood by staffs. 3. Evidence to reduce waste/rework present, visual control well applied, but standardized checklist not in place. 4. Evidence to reduce waste rework is present, visual control well applied, standardized checklist in place but not regularly used. 5. Evidence to reduce waste /rework through 5S well applied i.e. visual control present.					
	23	Ask/observe about concept of health and non-health expectations is considered to provide quality services	1. Staffs do not understand the concept of 5S-KAIZEN in relating to Quality Improvement. 2. Staffs are not considering use of the concept of 5S-KAIZEN to improve quality services. 3. Staffs understand the concept of 5S-KAIZEN activities in relating to quality but not implementing. 4. The staffs have 5S-KAIZEN concept and activities in relation to Quality Improvement but no record of the activities. 5. Staff have concept of 5S-KAIZEN activities appropriately considering quality of services i.e. work flow, waiting reduction, clean ward facility and appropriate consolation time and consolation.					
Cost	**24**	Ask/observe about awareness and consciousness on cost reduction of materials, labor, administrative cost, lowering of defects by introducing the concept of 5S-KAIZEN-TQM Approach	1. No awareness on measure to reduce/save cost i.e. waste of time, energy, unnecessary movement, electricity, and water etc. 2. Electricity and waterlines mechanism of cost but no measure to reduce/save cost on waste of time, energy and unnecessary movement. 3. Awareness of mechanism to reduce/save cost, applied less than three measures to reduce/save cost 4. Awareness measures are applied but not standardized. 5. Awareness measures are applied, and its evidences of cost reduction is observed.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
	25	Ask/observe about "Just in Time" concept is applied for inventory management	1. No evidence of lowering inventory cost, organization of the store, proper labeling, inventory list, regular control of stocks. 2. 2 of the above are applied with evidence. 3. 3 of the above are applied with evidence. 4. 4 of the above are applied with evidence. 5. All the above are applied with evidence.					
Safety	**26**	Ask/observe about safety measures to reduce/prevent incidents (near-miss), accidents and medical errors are in place and disseminated	1. No report book, and staff are not aware on importance of reporting incidents/accident/errors. 2. The report book is in place but not recorded and the staffs are not aware on importance of reporting incidents/accident/errors. 3. The report book is in place and few incidents/accidents/errors are recorded, but not reported to higher authority. 4. The report book is in place and some incidents/accidents/errors are recorded, but reported occasionally to higher authority. 5. The report book is in place and all incidents/accidents/errors are recorded, and reported periodically to higher authority.					
	27	Ask/observe about availability of the safety gears, vaccines and PEP to protect the internal and external clients	1. No SOPs/symbols, PPE for safety measures in place. 2. Staff aware but safety measures not in place. 3. Staff aware on safety measures but some measures in place. 4. SOPs, symbols, PPE of safety measures in place but not adhered. 5. SOPs, symbols, PPE of safety measures are in place and are well implemented.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
	28	Ask/observe about knowledge and skills of the staff on safety measures, and its proper utilization for internal and external clients	1. Staffs are not aware on safety measures, no knowledge, no symbols. 2. Safety measure and symbols are not in place although staffs are aware on necessity of safety measures. 3. Safety measures are in place but staffs have weak knowledge on its proper usage. 4. Safety measures are in place and staffs have enough knowledge on its proper usage. 5. Staffs have enough knowledge on use of safety measures (use of fire extinguisher, symbol and labeling for safety measure), and evidences of training conducted in section are in place.					
Delivery of services	**29**	Ask/observe about staff working in section are committed and able to deliver services in time	1. There is no evidence of services and products provided according to instruction/guidelines. 2. There is weak evidence of services and products provided according to instruction/guidelines. 3. There are incomplete instructions and evidences of services and products provided according to instruction/guidelines. 4. There is fair evidence of services and products provided according to instruction/guidelines. 5. There is evidences of services and products provided according to instruction/guidelines.					
	30	Ask/observe about mechanism in section is established to monitor quality of service and time of delivery of the service	1. There is no evidence of mechanism to reduce delivery time. 2. There is weak evidence of service and product provided according to instruction/guidelines. 3. There is incomplete evidence of mechanism to reduce delivery time. 4. There is fair evidence of mechanism to reduce delivery time. 5. There is evidence of mechanism to reduce delivery time.					
Morale	**31**	Ask/observe about 5S-KAIZEN mindset for TQM culture is raised within a section	1. Poor participation of staff for 5S-KAIZEN activities were observed. 2. No KAIZEN suggestions/ideas are raised from staff during WIT meeting with evidences. 3. Little KAIZEN suggestions/ideas are raised from staff during WIT meeting. 4. Many KAIZEN suggestions/ideas are raised from staff during WIT meeting with evidences. 5. WIT meeting is regularly conducted with good number of participants and discussion with evidences.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
WIT function	**32**	Ask/observe about responsibilities of WIT are carried out according to the plan	1. No clear roles and responsibilities of WIT were developed. 2. Roles and responsibilities of WIT were developed but not well known by WIT. 3. Roles and responsibilities of WIT are known by all WIT members but not well followed. 4. Roles and responsibilities of WIT are known by all WIT members and well followed. 5. WIT is performing well and implement their tasks according to the plan.					
	33	Ask/observe about WIT reports progress of 5S-KAIZEN activities done at respective department or section to QIT regularly with evidences, and availability of QIT inputs such as suggestions and recommendations	1. Progress of 5S-KAIZEN activities is not recorded and not reported to QIT. 2. Progress of 5S-KAIZEN activities is recorded occasionally but not reported. 3. Progress of 5S-KAIZEN activities is recorded occasionally and reported to QIT occasionally. 4. Progress of 5S-KAIZEN activities is well summarized and recorded regularly but reported to QIT occasionally. 5. Progress of 5S-KAIZEN activities well summarized and recorded, and reported to QIT regularly.					
	34	Ask/observe about self-monitoring of KAIZEN activities is regularly conducted by WIT and well recorded, and availability of QIT inputs such as suggestions and recommendations	1. Self-monitoring checklist on KAIZEN is not developed. 2. Self-monitoring checklist on KAIZEN is developed but not used. 3. Self-monitoring on KAIZEN is occasionally conducted but not recorded. 4. Self-monitoring on KAIZEN is occasionally conducted and recorded. 5. Self-monitoring on KAIZEN is conducted daily/weekly and well recorded, and the results is shared within the section.					

Categories	SQ #	Description	Marking criteria	Section				
				1	2	3	4	5
HR Empow-erment	**35**	Ask/observe about opportunity for section staff to update knowledge and skills on 5S-KAIZEN-TQM	1. No opportunity for staff to update knowledge and skills on 5S-KAIZEN-TQM Approach. 2. Skill building seminar/training is planned but not implemented. 3. Skill building seminar/training is conducted occasionally. 4. Different opportunities such as morning report, OJT and continuous education sessions are utilized for staff to update knowledge and skills on 5S-KAIZEN with evidences. 5. Regular activities on updating knowledge and skills on 5S-KAIZEN-TQM Approach is con-firmed with evidences.					
	36	Ask/observe about seminar and Training on 5S-KAIZEN-TQM are conducted for WIT members	1. No evidence of 5S-KAIZEN seminars and trainings. 2. 5S-KAIZEN seminars and trainings is under planning. 3. 5S-KAIZEN seminars and trainings is conducted occasionally. 4. Mechanism of 5S-KAIZEN seminars and trainings for newly posted staff and students under practical rotation is established. 5. The mechanism of 5S-KAIZEN seminars and trainings is well functioning and recorded.					

Annex C: Reporting format for reporting the findings from individual hospital

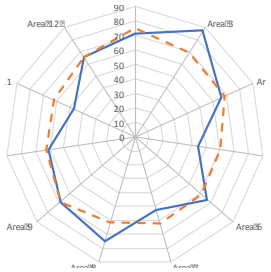
Sumbawanga Regional Referral Hospital (Rukuwa region)
Facility code: 107663-7

Basic information of the RRH

Bed capacity	202
Number of staff	308 (Staff shortage by 36%) *minimum requirement
Departments existing in the RRH	16 Dept., 56-Section
Top 10 diseases	Malaria, Anemia, Diarrhea Diseases, Trauma, Accidents, Animal Bites and Burns Pneumonia, Severe Malaria Pregnancy Complications HIV/AIDS. Acute Respiratory Infections, Diabetes

Pics: https://pbs.twimg.com/media/CZtRT1eWIAE5TUv.jpg

Average score of the EHPA



Overall EHPA average=64.3

Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Area 10	Area 11	Area 12
71.4	87.5	66.6	44.2	66.6	52.7	75	68.4	61.1	47	66.1

Health Promotion Services, Radiology and Imaging, Client Service Charter were identified as weak subareas with the score of less than 40%. On the other hand, Information Use and Dissemination, Referral Mechanism, Utilities, Laboratory Services were identified as best performance sub-areas with the score of 100%.

Key strong points

- Availability of regular internal quality assessment
- Availability of strategic plan, a well-prepared CHOP and involvement of HAB in planning
- Installation of electronic revenue collection –GoTHoMIS and improved revenue collection
- Internal Supportive Supervision conducted as per schedule
- Data analysis is done and applied in planning i.e. CHOP and in decisions making
- Staff are satisfied with performance appraisal system
- Functional team well trained on handling emergencies is available
- Mechanism for capturing client feedback and complaints is available
- Availability of well-functioning, oriented and active HAB
- Staff trained on PPM and implementation reports are available

Key Weak points

- HRHIS data is not updated
- Inactive and nonfunctioning WIT to most of the departments except Laboratory
- Identified gaps during ISS are not implemented in all service areas except Laboratory
- Inpatients information not easy to retrieve and confidentiality is not observed
- Most of staff are not aware with client/core health care services charter
- Summary of plans, budget, allocated medicines and supplies, income and expenditure not displayed
- Triage system not functional
- No feedback mechanisms for referred clients
- No PPM annual plans
- Some hospital areas are not clean and organized
- Antiseptic and disinfectant are not stored according to IPC guideline
- Lack of some tracer medicine

Key Suggestions

RRHMT to:

- Make plan to address identified gaps
- Conduct scheduled Internal Supportive Supervision
- Avail and ensure use of all required guidelines, SOPs and protocols
- share performance reports timely
- Strengthening of QIT
- Revive WIT functionality
- For gap that require funds should be included in development of CHOP

Pictures

Staff movement is not considered to put furniture

Good storage of medicine at pharmacy store

Damaged sealing in a ward

Good arrangement of workplace at OPD

Supported by Japan International Cooperation Agency (JICA)