

UNITED NATIONS
ASSESSMENT MANUAL
FOR
REFERRAL HOSPITALS



The United Nations (UN) is committed to providing a consistent level of high quality care to all mission personnel, regardless of the country, situation or environment in which he or she receives medical treatment.

In many countries, the UN contracts with hospitals outside of the UN system to provide care for mission personnel. These hospitals are a valuable resource for the UN to ensure every patient has the care they need when they need it.

Standards have been compiled in this *United Nations Assessment Manual for Referral Hospitals* to assist UN staff to assess the service capability of these hospitals.

The Manual is comprised of three sections:

- Section I, International Patient Safety Goals
- Section II, Clinical-Focused Standards
- Section III, Administration-Focused Standards

Section I UNR International Patient Safety Goals (UNR-IPSG)

Goal 1: Patient Identification

Standard UNR-IPSG.1

The hospital has a process to improve accuracy of patient identification.

Intent of UNR-IPSG.1

Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. Patients may be sedated, disoriented, not fully alert, or comatose; may change beds, rooms, or locations within the hospital; may have sensory disabilities; may not remember their identity; or may be subject to other situations that may lead to errors in correct identification. The intent of this goal is first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual.

The identification process used throughout the hospital requires at least two ways in which to identify a patient, such as the patient's name and birth date. The patient's room number or location cannot be used for identification. Two different identifiers are utilized in all locations within the hospital.

Two different patient identifiers are required in any circumstance involving patient interventions. These include before administering medications, blood or blood products; before taking blood and other specimens for clinical testing; and before performing procedures and treatments.

Measurable Elements of UNR-IPSG.1

1. Patients are identified using the minimum (mandatory) of patient's name and date of birth.
2. Patients are identified before providing treatments and procedures.
3. Patients are identified before any diagnostic procedures.

Goal 2: Improve Effective Communication

Standard UNR-IPSG.2

The hospital has and utilizes a policy regarding the use of verbal orders.

Standard UNR-IPSG.2.1

The hospital has and utilizes a process for reporting critical results of diagnostic tests.

Standard UNR-IPSG.2.2

The hospital has and utilizes a process for handover communication.

Intent of UN-IPSG.2 through UN-IPSG.2.2

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, or written, or in emergency situations, verbal. Patient care circumstances that can be critically impacted

by poor communication include patient care orders, communication of critical test results, and hand-over communications. For example, drug names and numbers which sound alike, such as erythromycin instead of azithromycin or fifteen instead of fifty, can affect the accuracy of the order.

The reporting of critical results of diagnostic tests is also a patient safety issue. This includes critical results from any diagnostic tests performed at the bedside, such as point-of-care testing. Results that are significantly outside the normal range may indicate a high-risk or life-threatening condition.

Essential patient information is communicated among those caring for the patient during patient hand-overs through the use of standardized patient records, information exchange between shifts of nurses and when a patient is transferred to another hospital.

Measurable Elements of UNR-IPSG.2

1. The complete physician order is documented.
2. When a verbal order is permitted by policy and/or is unavoidable, such as in the ER or in the OR, the order is documented and signed by the ordering physician.

Measurable Elements of UNR-IPSG.2.1

1. The hospital has defined critical values for each type of diagnostic test.
2. The hospital has identified how, by whom, and to whom critical results of diagnostic tests are reported.
3. The hospital has identified what information is documented in the patient record.

Measurable Elements of UNR-IPSG.2.2

1. Standardized critical content is communicated between health care providers during hand-overs of patient care.
2. The content of the medical record is available to all those caring for a patient, and the content is standardized, including the use of any abbreviations, signs, and symbols, and for medication changes.
3. There is a process to periodically review a sample of patient records, and this information is used to improve completeness, legibility, and accuracy of the content of all patient records.
4. The hospital uses standardized forms during handover communication.

Goal 3: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery

Standard UNR-IPSG.3

The hospital implements a process for ensuring correct-site, correct-procedure, and correct-patient surgery.

Standard UNR-IPSG.3.1

The hospital implements a process for Time Out that is performed in the operating theatre immediately prior to the start of surgery to ensure correct-site, correct-procedure, and correct-patient surgery.

Intent of UNR-IPSG.3 and UNR-IPSG.3.1

Wrong-site, wrong-procedure, wrong-patient surgery is an alarmingly common occurrence in hospitals. These errors are the result of ineffective or inadequate communication between members of the surgical team, lack of patient involvement in site marking, and lack of procedures for verifying the operative site.

Surgery and invasive procedures include all procedures that investigate and/or treat diseases and disorders of the human body through cutting, removing, altering, or insertion of diagnostic/therapeutic scopes. The approach the hospital takes to ensuring correct-site, correct-procedure, and correct-patient surgery applies to all areas of the hospital in which surgical and invasive procedures occur.

Evidence-based practices are described in the WHO Surgical Safety Checklist. The essential processes are:

- marking the surgical site;
- a preoperative verification process; and
- a time-out that is held immediately before the start of a procedure.

Marking the surgical and invasive procedure site involves the patient and is done with an instantly recognizable mark. The mark must be consistent throughout the hospital; must be made by the person performing the procedure; should take place with the patient awake and aware, if possible; and must be visible after the patient is prepped and draped. The surgical site is marked in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).

The purpose of the preoperative verification process is to:

- verify the correct site, procedure, and patient;
- ensure that all relevant documents, images, and studies are available, properly labeled, and displayed; and
- verify that any required special medical technology is present.

The time-out, held immediately before the start of the procedure with all team members present, permits any unanswered questions or confusion to be resolved. The time-out is conducted in the location at which the procedure will be done, just before starting the procedure, and involves the entire operative team. The patient will likely be under pre-operative sedation and does not have to participate in the time-out procedure

Measurable Elements of UNR-IPSG.3

1. The hospital uses an instantly recognizable mark for surgical and invasive procedure site identification that is consistent throughout the hospital.

2. Surgical and invasive procedure site marking is done by the person performing the procedure and, when possible, involves the patient in the marking process.
3. The hospital uses the WHO Surgical Safety Checklist and documents this in the patient record

Measurable Elements of UNR-IPSG.3.1

1. The full surgical team conducts and documents a Time Out procedure in the area in which the surgery/invasive procedure will be performed, just before starting a surgical/invasive procedure.
2. The components of the Time Out include correct patient identification, correct site and side, agreement of the procedure to be done, and confirmation that the verification process has been completed.
3. When surgery is performed, including medical and dental procedures done in settings other than the operating theatre, the hospital uses uniform processes to ensure the correct site, correct procedure, and correct patient.
4. The Time Out is documented.

Goal 4: Reduce the Risk of Health Care-Associated Infections

Standard UNR-IPSG-4

The hospital utilizes WHO Guidelines for Hand Hygiene in Health Care to reduce the risk of health care–associated infections.

Intent of UNR-IPSG.4

Infection prevention and control are challenging in most health care settings, and rising rates of health care–associated infections are a major concern for patients and health care practitioners. Infections common to all health care settings include catheter-associated urinary tract infections, bloodstream infections, and pneumonia, often associated with mechanical ventilation.

Central to the elimination of these and other infections is proper hand hygiene. Internationally acceptable hand-hygiene guidelines are available from the World Health Organization (WHO). Hand-hygiene guidelines and information materials are posted in appropriate areas, and staff members are educated in proper hand-washing and hand-disinfection procedures. Soap, disinfectants, and towels or other means of drying are located in those areas where hand-washing and hand-disinfecting procedures are required.

Measurable Elements of UNR-IPSG.4

1. The hospital uses and follows the current WHO Guidelines for Hand Hygiene in Health Care.
2. The hospital has a written policy for implementing an effective hand-hygiene program throughout the entire facility.
3. Hand-washing and hand-disinfection procedures are used in accordance with hand-hygiene guidelines and information materials throughout the hospital.

Section II Clinical Focused Standards

Chapter 1 - Access to Care (UNR-AC)

Standard UNR-AC.1

On admission, inpatients receive information on the proposed care and the expected outcomes of care.

Intent of UNR-AC.1

During the admission process, patients receive sufficient information, in a method they can understand, to make knowledgeable decisions. Information is provided about the proposed care and the expected outcomes. Such information can be in written form or provided verbally, noting such in the patient's record.

Measurable Elements of UNR-AC.1

1. At admission, the patient is provided with information in a method they can understand.
2. The information includes proposed care.
3. The information includes expected outcomes of care.

Chapter 2 - Continuity of Care (UNR-CC)

Standard UNR-CC.1

A complete discharge summary is prepared for all inpatients.

Intent of UNR-CC.1

The discharge summary provides an overview of the patient's stay within the hospital.

Measurable Elements of UNR-CC.1

1. The discharge summary contains the reason(s) for admission, diagnoses, and comorbidities.
2. The discharge summary contains significant physical and other findings.
3. The discharge summary contains diagnostic and therapeutic procedures performed.
4. The discharge summary contains significant medications, including discharge medications.
5. The discharge summary contains the patient's condition/status at the time of discharge.
6. The discharge summary contains follow-up instructions.

Standard UNR-CC.2

Patient education and follow-up instructions are given in a form and language the patient can understand.

Intent of UNR-CC.2

For patients not immediately transferred back to a UN facility, clear instructions on where and how to receive continuing care are essential to ensure that all care needs are met. The instructions include any return to the hospital for follow-up, and when urgent care should be obtained.

The hospital provides the instructions to the patient and, as appropriate, his or her family in a simple, understandable manner. The instructions are provided in writing or in the form most understandable to the patient when the patient is not able to understand written instructions. The hospital must confirm that the patient understands what he or she is being told. If this understanding cannot be confirmed, the hospital takes necessary steps to obtain reliable interpretation assistance in the language of the patient. Final confirmation of understanding must be documented in the patient record.

Measurable Elements of UNR-CC.2

1. Follow-up instructions are provided in writing and in a form and language the patient can understand.
2. The instructions include any return for follow-up care.
3. The instructions include when to obtain urgent care.

Standard UNR-CC.3

A discharge summary is provided to the referring physician and the patient on discharge, and a copy is placed in the patient record.

Intent of UNR-CC.3

For effective follow up care, the patient's condition and treatment must be known by the referring physician at the time of the patient's discharge. The discharge summary completes the patient record by documenting the patient's care and current condition, and serves as a concise reference should the patient return to the hospital.

Measurable Elements of UNR-CC.3

1. A discharge summary is prepared by a qualified individual.
2. A copy of the discharge summary is given to the patient and provided to the referring physician.
3. The completed discharge summary is also placed in the patient's record at the time of discharge.

Standard UNR-CC.4

The hospital has a process for the management and follow-up of patients who notify hospital staff that they intend to leave against medical advice.

Intent of UNR-CC.4

When a patient decides to leave the hospital after an examination has been completed and a treatment plan recommended, this is identified as "leaving against medical advice." Patients have the right to refuse medical treatment. However, these patients may be at risk, which may result in permanent harm or death. When a competent patient requests to leave the hospital without medical approval, the medical risks must be explained by the physician providing the treatment plan or his or her designee prior to discharge. Efforts should be made to identify the reason the patient is choosing to leave against medical advice. The patient's referring physician must be notified at the time the patient notifies the hospital and prior to the patient leaving the facility.

Measurable Elements of UNR-CC.4

1. The hospital's process for managing patients who notify staff that they are leaving against medical advice is followed.
2. The process includes informing the patient of the medical risks of inadequate treatment.
3. The patient's referring physician is informed prior to the patient leaving the facility.
4. The process is consistent with local rules and regulations, including requirements for reporting cases of infectious disease and cases in which patients may be a threat to themselves or others.

Standard UNR-CC.5

The hospital has a process for the management of patients who leave the hospital against medical advice without notifying hospital staff.

Intent of UNR-CC5

When a patient leaves the hospital against medical advice without notifying anyone in the hospital, or an outpatient receiving complex or lifesaving treatment does not return for treatment, the hospital must notify the patient's referring physician.

When applicable, the hospital reports cases of infectious disease and provides information regarding patients who may harm themselves or others to local health authorities and the patient's referring physician.

Measurable Elements of UNR-CC.5

1. The hospital's process for the management of patients who leave the hospital against medical advice without notifying hospital staff is followed, and includes immediate notification of the patient's referring physician.
2. The hospital's process for the management of outpatients receiving complex treatment who do not return for treatment is followed, and this includes immediate notification of the patient's referring physician.
3. The process is consistent with applicable local regulations, including requirements for reporting cases of infectious disease and cases in which patients may be a threat to themselves or others to local authorities.

Chapter 3 - Assessment of Patients (UNR-AP)

Standard UNR-AP.1

All inpatients and outpatients are screened for pain and assessed when pain is present.

Intent of UNR-AP.1

During the initial assessment and during any reassessments, a screening procedure is used to identify patients with pain.

Positive answers to questions regarding the presence of pain indicate the need for a more in-depth assessment of the patient's pain. When pain is identified in the outpatient setting, the patient may be more thoroughly assessed and treated in the hospital, if necessary.

When the patient is an inpatient, a more comprehensive assessment is performed as soon as pain is identified. This assessment measures pain intensity and quality, such as pain character, frequency, location, and duration. Additional information may include pain history, what makes pain better or worse, what are the patient's goals for pain relief, and the like. This assessment is recorded in a way that facilitates regular reassessment and follow-up per criteria developed by the hospital and the patient's needs.

Measurable Elements of UNR-AP.1

1. Patients are screened for pain.
2. When pain is identified from the initial screening exam, a comprehensive assessment of the patient's pain is performed.
3. The assessment is recorded in a way that facilitates regular reassessment and follow-up per criteria developed by the hospital and the patient's needs.

Standard UNR-AP.2

All patients are clinically reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.

Intent of UNR-AP.2

Reassessment of the patient is key to understanding whether care decisions are appropriate and effective. Patients are reassessed throughout the care process at intervals based on their needs and plan of care or as defined in hospital policies and procedures. The results of these reassessments are noted in the patient's record.

Reassessment by a physician is integral to ongoing patient care. A physician assesses an acute care patient at least daily, including weekends, and whenever there has been a significant change in the patient's condition.

Measurable Elements of UNR-AP.2

1. Patients are reassessed to determine their response to treatment and plan for continued treatment and/or discharge.
2. Patients are reassessed at intervals based on their condition and when there has been a significant change in their condition, plan of care, or individual needs.
3. A physician reassesses patients at least daily, including weekends, during the acute phase of their care and treatment.
4. Reassessments are documented in the patient record.

Laboratory Services

Standard UNR-AP.3

A laboratory safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.

Intent of UNR-AP.3

The laboratory has an active safety program to the degree required by the risks and hazards encountered in the laboratory. The program addresses safety practices and prevention measures (for example, eye-wash stations, spill kits, and the like) for laboratory staff, other staff, and patients when present. The laboratory program is coordinated with the hospital's facility management and infection control programs.

The laboratory safety management program includes:

- compliance with standards addressing facility management and infection control programs;
- availability of safety devices appropriate to the laboratory's practices and hazards encountered;
- the orientation of all laboratory staff to safety procedures and practices; and
- in-service education for new procedures and newly acquired or recognized hazardous materials.

Measurable Elements of UNR-AP.3

1. The laboratory program is part of the hospital's facility management and infection control programs.
2. Laboratory staff members are oriented to safety procedures and practices and receive ongoing education and training for new practices and procedures.

Standard UNR-AP.4

The laboratory uses a coordinated process to reduce the risks of infection because of exposure to bio-hazardous materials and waste.

Intent of UNR-AP.4

Policies, procedures, and practices are in place to reduce the hazards of exposure to bio-hazardous materials. Infections acquired in the laboratory are reported.

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

Measurable Elements of UNR-AP.4

1. The laboratory has a defined process for reducing the risks of infection.
2. Infections acquired in the laboratory are reported, as defined in hospital policy.
3. The laboratory follows biosafety rules for relevant practices.

Standard UNR-AP.5

All equipment and medical technology used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

Intent of UNR-AP.5

Laboratory staff members work to ensure that all equipment and medical technology, including medical devices used for point-of-care testing, function at acceptable levels and in a manner that is safe to the staff.

Testing, maintenance, and calibration frequency are related to the laboratory's use of its equipment and medical technology and its documented history of service.

Measurable Elements of UNR-AP.5

1. The laboratory develops, implements, and documents a program to manage laboratory equipment and medical technology.
2. There is a documented inventory of all laboratory equipment and medical technology.
3. Laboratory equipment and medical technology are inspected and tested when new and according to age, use, and manufacturers' recommendations thereafter and the inspections are documented.
4. The hospital has a system in place for monitoring and acting on laboratory equipment and medical technology hazard notices, recalls, reportable incidents, problems, and failures.

Radiology and Diagnostic Imaging Services

Standard UNR-AP.6

Radiology and diagnostic imaging services are available to meet patient needs, and all such services meet applicable radiation protection measures and applicable standards.

Intent of UNR-AP.6

The hospital has a system for providing radiology and diagnostic imaging services required by its patient population, clinical services offered, and health care practitioner needs. Radiology and diagnostic imaging services meet all applicable local and national standards, laws, and regulations.

Measurable Elements of UNR-AP.6

1. Radiology and diagnostic imaging services meet industry standards.
2. Adequate, regular, and convenient radiology and diagnostic imaging services are available to meet patient needs.

Standard UNR-AP.7

A radiation safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.

Intent of UNR-AP.7

The hospital has an active radiation safety program that is compliant with industry standards. The program is consistent with standards addressing facility management and infection control programs. The program addresses safety practices and prevention measures for radiology and diagnostic imaging staff, other staff, and patients, and provides in-service education for new procedures and newly acquired or recognized hazardous materials.

Measurable Elements of UNR-AP.7

1. A radiation safety program is in place that addresses potential safety risks and hazards encountered within or outside the department.
2. Identified radiation safety risks are addressed by specific processes or devices that reduce safety risks (such as lead aprons, radiation badges, and the like).

Standard UNR-AP.8

All equipment and medical technology used to conduct radiology and diagnostic imaging studies is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

Intent of UNR-AP.8

Radiology and diagnostic imaging staff work to ensure that all equipment and medical technology function at acceptable levels and in a manner that is safe to the operator(s). Testing, maintenance, and calibration frequency are related to the use of the equipment and medical technology and its documented history of service.

Radiology and diagnostic imaging develops and implements a program to manage equipment and medical technology.

Measurable Elements of UNR-AP.8

1. Radiology and diagnostic imaging develops, implements, and documents a program to manage equipment and medical technology.
2. Radiology equipment and medical technology are inspected and tested when new and according to age, use, and manufacturers' recommendations.
3. Radiology equipment and medical technology are calibrated and maintained per manufacturers' recommendations.
4. The hospital has a system in place for monitoring and acting on radiology equipment and medical technology hazard notices, recalls, reportable incidents, problems, and failures.

Chapter 4 - Care of Patients (UNR-CP)

Standard UNR-CP.1

Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient's record.

Intent of UNR-CP.1

A clinical record that contains documentation of all invasive and non-invasive diagnostic procedures and treatments, and the results of the same, becomes a real-time resource for clinical decision-making.

Measurable Elements of UNR-CP.1

1. Procedures and treatments performed are documented in the patient's record.
2. The person requesting, and the reason for requesting the procedure or treatment are documented in the patient's record.
3. The results of procedures and treatments performed are documented in the patient's record.

Standard UNR-CP.2

The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, clinical pathways, and policies.

Intent of UNR-CP.2

The frightened, confused, comatose, or emergency patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Care for these high-risk patients is supported, when possible, by the use of tools such as, guidelines, procedures, care plans, clinical pathways, and the like. Clinical pathways may be utilized for a) malaria, b) sepsis, c) chest pain, d) head injury, e) DVT and f) Trauma and/or others identified by the hospital

Hospital leadership also identifies additional risk as the result of any procedures or plan of care (for example, pressure injury, ventilator-associated infections in patients on life support; central line infections; and falls). Such risks, when present, need to be addressed and prevented by educating staff and developing appropriate policies, guidelines, and procedures.

Measurable Elements of UNR-CP.2

1. Hospital leadership has identified the high-risk patients and services.
2. Staff are educated through policies, guidelines and procedures on the care of high-risk patients.
3. Clinical pathways are utilized as appropriate.

Standard UNR-CP.3

Clinical staff is trained to recognize and respond to changes in a patient's condition.

Intent of UNR-CP.3

Serious adverse events such as unexpected death and cardiac arrest are often preceded by observable physiological abnormalities. Early identification of deterioration may improve outcomes and lessen the intervention required to stabilize patients whose condition deteriorates in the hospital.

Measurable Elements of UNR-CP.3

1. The hospital implements an observation and response process for recording physiological observations that incorporates triggers to escalate care when deterioration occurs.
2. Action is taken when physiologic triggers are met.
3. Data are collected about the recognition and response system and are used to improve the process.

Standard UNR-CP.4

Clinical guidelines and procedures are implemented for the handling, use, and distribution of blood and blood products.

Intent of UNR-CP.4

Guidelines and procedures describe the process for:

- a. procurement of blood from the blood storage area;
- b. patient identification;
- c. blood administration;
- d. monitoring of the patient; and
- e. identification and response to signs of potential transfusion reactions.

Measurable Elements of UNR-CP.4

1. An individual with education, knowledge, and expertise oversees the administration of blood and blood products.
2. Clinical guidelines and procedures are implemented for the handling, use, and administration of blood and blood products.
3. Clinical guidelines and procedures address the processes for a) through e) in the intent.

Standard UNR-CP.5

Patients are supported in managing pain effectively.

Intent of UNR-CP.5

Pain can be a common part of the patient experience, especially in crisis and/or emergency situations. It may also be an expected part of certain treatments, procedures or examinations. Whatever the origin of pain, unrelieved pain has adverse physical and psychological effects.

Measurable Elements of UNR-CP.5

1. Based on the scope of services provided, the hospital has processes to manage patients in pain.
2. When pain is an expected result of planned treatments, procedures, or examinations, patients are informed about the likelihood of pain and options for pain management and these are documented in the patient's medical record.
3. Patients are reassessed following any treatment or procedure and pain is managed on an ongoing basis.

Chapter 5 - Anesthesia and Surgical Care (UNR-AS)

Anesthesia and procedural sedation are commonly viewed as a continuum from minimal sedation to full anesthesia.

Anesthesia

Standard UNR-AS.1

Sedation and anesthesia services are available to meet patient needs, and are under the supervision of the facility's specialty anesthetist.

Intent of UNR-AS.1

The selection of the appropriate (lowest risk) anesthesia is based on the patient's medical history physical examination, medications used by the patient and other health issues or co-morbidities.

Measurable Elements of UNR-AS.1

1. Sedation and anesthesia services are available to meet patient needs.
2. Sedation and anesthesia services are available for emergencies at all hours of hospital operation.

Sedation Care

Standard UNR-AS.2

The administration of procedural sedation is standardized.

Intent of UNR-AS.2

Procedural sedation is defined as "...a technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardiorespiratory function." Procedural sedation may be performed in many areas of the hospital outside of the operating theatre. The qualifications of staff participating in the procedure, the medical equipment, the supplies, and the monitoring must be the same wherever procedural sedation is provided in the hospital. During procedural sedation, an individual trained in advanced life support and emergency medical equipment and supplies appropriate for the age and history of the patient and the type of procedure being performed is immediately available, and is under the supervision of the facility specialty anesthetist.

Measurable Elements of UNR-AS.2

1. At the least, during procedural sedation patients must be on oxygen and a pulse oximeter.
2. Emergency medical equipment and supplies are immediately available and customized to the type of sedation being performed and the age and clinical condition of the patient.
3. An individual with advanced life-support training appropriate for the age and history of the patient is immediately available when procedural sedation is being performed.

Standard UNR-AS.3

There is a pre-sedation assessment of the patient performed by a qualified professional, under the supervision of the facility specialist anesthetist.

Intent of UNR-AS.3

To reduce any complications of procedural sedation for the patient, a pre-sedation assessment serves the purpose of evaluating risk and appropriateness based on the patient's current health status. Close monitoring occurs following sedation and criteria are used during the recovery process and for discharge from the recovery area to another level of care.

Measurable Elements of UNR-AS.3

1. There is a pre-sedation assessment performed and documented to evaluate risk and appropriateness of procedural sedation for the patient.
2. A qualified individual monitors the patient during the period of sedation and documents at least: pulse, respiration rate, oxygen saturation, blood pressure, and level of consciousness.
3. Established criteria are used and documented for the recovery and discharge from procedural sedation.

Standard UNR-AS.4

The risks, benefits, and alternatives related to procedural sedation are discussed with the patient.

Intent of UNR-AS.4

The procedural sedation planning process includes educating the patient or decision maker on the risks, benefits, and alternatives related to procedural sedation. This discussion occurs as part of the process to obtain consent for procedural sedation.

Measurable Elements of UNR-AS.4

1. The patient, and/or decision maker is educated on the risks, benefits, and alternatives of procedural sedation.
2. The patient, and/or decision maker is educated about post-procedure analgesia.

Anesthesia Care

Standard UNR-AS.5

A qualified individual, under the supervision of the facility specialist anesthetist, conducts a pre-anesthesia assessment and pre-induction assessment.

Intent of UNR-AS.5

Because anesthesia carries an elevated level of risk, administration is carefully planned. The patient's pre-anesthesia assessment is the basis for that plan, for identifying what findings from monitoring during anesthesia and recovery may be significant, and for the use of postoperative analgesia.

An anesthetist or another qualified individual under the supervision of the facility specialist anesthetist conducts the pre-anesthesia assessment. The pre-anesthesia assessment may be carried out some time prior to admission or prior to the surgical procedure or shortly before the surgical procedure, as in emergency patients.

The pre-induction assessment is separate from the pre-anesthesia assessment, as it focuses on the physiological stability and readiness of the patient for anesthesia and occurs immediately prior to the induction of anesthesia. When anesthesia must be provided emergently, the pre-anesthesia assessment and pre-induction assessment may be performed immediately following one another, or simultaneously, but are documented independently.

Measurable Elements of UNR-AS.5

1. A pre-anesthesia assessment is performed for each patient.
2. A separate pre-induction assessment is performed to reevaluate patients immediately before the induction of anesthesia. See WHO Anesthesia Safety Checklist.¹

Standard UNR-AS.6

Each patient's anesthesia care is planned and documented, and the anesthesia and technique used are documented in the patient's record.

Intent of UNR-AS.6

Anesthesia care is carefully planned so the patient will have the fewest possible anesthesia related effects or complications, and the plan is documented in the anesthesia record. The plan identifies the anesthesia to be used, the method of administration, other medications and fluids, monitoring procedures, and anticipated post-anesthesia care.

Measurable Elements of UNR-AS.6

1. The anesthesia care of each patient is planned and documented in the patient's medical record.
2. The anesthesia agent, dose (when applicable), and anesthetic technique are documented in the patient's anesthesia record.

Standard UNR-AS.7

The risks, benefits and alternatives related to anesthesia and post-operative pain control are discussed with the patient and/or those who make decisions for the patient.

Intent of UNR-AS.7

The anesthesia planning process includes educating the patient or decision maker on the risks, benefits, and alternatives related to the planned anesthesia and postoperative analgesia. This discussion occurs as part of the process to obtain consent for anesthesia. A specialty anesthetist or a qualified individual provides this education.

¹ <http://www.who.int/surgery/publications/s15980e.pdf>

Measurable Elements of UNR-AS.7

1. The patient and/or decision makers are educated by an anesthetist or other qualified individual on the risks, benefits, and alternatives of anesthesia, and this is documented.
2. The patient and/or decision makers are educated, prior to the procedure being performed, about the options available for postoperative pain management, and this is documented.

Standard UNR-AS.8

Each patient's physiological status during anesthesia and surgery is monitored according to World Health Organization professional practice guidelines, and documented in the patient's record.

Intent of UNR-AS.8

Physiological monitoring provides reliable information about the patient's status during anesthesia (general, spinal, regional, and local) and the recovery period. Results of monitoring trigger key intra-operative decisions as well as postoperative decisions, such as return to surgery, transfer to another level of care, or discharge. Monitoring information guides medical and nursing care and identifies the need for diagnostic and other services. Monitoring findings are entered into the patient's medical record.

Monitoring methods depend on the patient's pre-anesthesia status, the anesthesia choice, and the complexity of the surgical or other procedure performed during anesthesia. In all cases, however, the overall monitoring during anesthesia and surgery is consistent with professional practice, and the results of monitoring are documented in the patient's record.

Measurable Elements of UNR-AS.8

1. The frequency and type of monitoring during anesthesia and surgery are based on the patient's pre-anesthesia status, the anesthesia used, and the surgical procedure performed.
2. Monitoring of the patient's physiological status includes at least: pulse, respiration rate, oxygen saturation, blood pressure, and level of consciousness.
3. The results of monitoring are documented in the patient's medical record on a dedicated UN designated record sheet.

Standard UNR-AS.9

Each patient's post anesthesia status is monitored and documented and the patient is discharged from the recovery area by a qualified individual.

Intent of UNR-AS.9

Monitoring during the anesthesia period is the basis for monitoring during the post-anesthesia recovery period. The ongoing, systematic collection and analysis of data on the patient's status while in recovery support decisions about moving the patient to other settings and less-intensive services. Recording of monitoring data provides the documentation to support discontinuing recovery monitoring and discharge decisions. When the patient is transferred directly from the operating theatre to a receiving unit, monitoring and documentation are the same as would be required in the recovery room.

The time of arrival at, and discharge from the recovery area (or the time recovery begins and the time of discontinuation of recovery monitoring) are documented in the patient's medical record.

Measurable Elements of UNR-AS.9

1. Patients are monitored during the post-anesthesia recovery period.
2. Monitoring findings are documented in the patient's medical record.
3. Time recovery is started and time recovery phase is complete are recorded in the patient's medical record.

Surgical Care

Standard UNR-AS.10

Each person's surgical care is planned and documented based on the results of the preoperative assessments, and pre-operative diagnosis is recorded.

Intent of UNR-AS.10

The surgical care planned for the patient is documented in the patient's medical record, including a preoperative diagnosis. The name of the surgical procedure alone does not constitute a diagnosis.

Measurable Elements of UNR-AS.10

1. The assessment information used to develop and to support the planned invasive procedure is documented in the patient's medical record before the procedure is performed.
2. A preoperative diagnosis is documented in the patient's medical record prior to the procedure.

Standard UNR-AS.11

The risks, benefits, and alternatives to surgery are discussed with the patient and/or those who make decisions for the patient.

Intent of UNR-AS.11

Patients and/or decision makers receive adequate information to participate in care decisions and to provide the informed consent required. The information includes:

- the risks of the planned procedure;
- the benefits of the planned procedure;
- the potential complications; and
- the surgical and nonsurgical options (alternatives) available to treat the patient.

In addition, when blood or blood products may be needed, information on the risks and alternatives is discussed. The patient's surgeon or other qualified individual provides this information.

Measurable Elements of UNR-AS.11

1. There is a defined process for patients to grant informed consent and the hospital uses the UN designated patient consent form(s).

2. Informed consent is obtained at least before surgery, anesthesia, use of blood and blood products, and other high-risk treatments and procedures.
3. Data are collected on surgical complications and incidents and the data are used to improve surgery safety.

Standard UNR-AS.12

Information about the surgical procedure is documented in the patient's medical record to facilitate continuing care.

Intent of UNR-AS.12

All actions and results essential to the patient's condition are entered in the patient's record.

The documented information about the surgery includes at least:

- a) postoperative diagnoses;
- b) name of operative surgeon and assistants;
- c) procedures performed and descriptions of each procedure findings;
- d) perioperative complications and/or adverse events;
- e) amount of blood loss and amount of transfused blood, and
- f) date, time and signature of responsible physician.

Some information may be contained in other notations in the record. For example, amount of blood loss and transfused blood may be recorded in the anesthesia record.

Measurable Elements of UNR-AS.12

1. Surgical reports, templates, or operative progress notes include at least a) through f) in the Intent Statement.
2. The surgical report, template, or operative progress note is available immediately after surgery before the patient is transferred to the next level of care.
3. Inter-operative complications and adverse events are documented.
4. Inter-operative complications and adverse events are reviewed and data are used to improve performance.

Standard UNR-AS.13

Patient care after surgery is planned and documented.

Intent of UNR-AS.13

Post-surgical care planning can begin before surgery based on the patient's assessed needs and condition and the type of surgery being performed. The post-surgical plan of care also includes the patient's immediate postoperative needs.

Measurable Elements of UNR-AS.13

1. The post-surgical care plan meets the patient's immediate post-surgical needs.
2. The continuing post-surgical plan(s) is documented in the patient's medical record

Chapter 6 - Medication Management (UNR-MM)

Standard UNR-MM.1

Medication use is safely managed.

Intent of UNR-MM.1

A written document identifies how medication use is structured and managed throughout the hospital. Medication use is overseen by a qualified individual.

Measurable Elements of UNR-MM.1

1. All settings, services, and individuals who manage medication processes are included in the medication management structure.
2. Medication use is overseen by a qualified individual.

Storage of Medications

Standard UNR-MM.2

Medications are properly and safely stored.

Intent of UNR-MM.2

Medication use is a complex system of processes that has many risk points. There must be a qualified individual familiar with and responsible for all parts of the medication use system.

Measurable Elements of UNR-MM.2

1. Medications are stored under conditions suitable for product stability, including medications stored on individual patient care units. All medication storage areas, including those on patient care units, are periodically inspected to ensure that medications are stored properly.
2. Controlled substances are accurately accounted for using a process that includes verification by at least two staff members.
3. The hospital has and follows a process to maintain a “cold chain” for medications.

Standard UNR-MM.3

A system is used to safely dispense medications in the right dose to the right patient at the right time.

Intent of Standard 3

The hospital dispenses medications in the most ready-to-administer form possible to minimize opportunities for error during distribution and administration.

Measurable Elements of UNR-MM.3

1. There is a uniform medication dispensing and distribution system in the hospital.

2. Medications are dispensed in the most ready-to-administer form available.
3. After preparation, medications not immediately administered are labeled with the name of the medication, the dosage/concentration, the date prepared, the expiration date, and two patient identifiers.

Standard UNR-MM.4

Medication effects on patients are monitored.

Intent of UNR-MM.5

Monitoring medication effects includes observing and documenting any adverse effects, which informs the physician of next steps in treatment. The hospital has a policy that identifies all adverse effects that are to be recorded and those that must be reported.

Measurable Elements of UNR-MM.4

1. Medication effects on patients are monitored.
2. Medication adverse effects on patients are monitored and documented.
3. Adverse effects are reported per hospital policy.

Section III - Administration-Focused Standards

Chapter 7 - Quality and Patient Safety (UNR-QPS)

Excellent hospitals have experience in setting improvement priorities, collecting data, displaying data for better analysis, and finally, planning and implementing improvement strategies. When leaders are committed to quality improvement and value the data that form the basis of evidence-based learning, the hospital's culture is focused on quality and safety. This helps create a non-punitive environment and encourages a reporting system for adverse events.

Standard UNR-QPS.1

The hospital follows an established adverse event reporting process.

Intent of UNR-QPS.1

The frequency, magnitude and impact of adverse events can only be known if data are collected and analyzed. A difficult challenge is to develop a reporting process that is free of punitive overtones and/or actions. Without this, staff are fearful, adverse events are under-reported, and any resulting data and data analysis are flawed. The adverse event reporting process should be clearly defined, and staff should be well-educated on the process of reporting. Adverse event reports are completed on at least the following:

- a) All confirmed transfusion reactions, if applicable to the hospital
- b) All serious adverse drug events as defined by the hospital
- c) All significant medication errors as defined by the hospital
- d) Adverse events or patterns of adverse events during procedural sedation regardless of administration site
- e) Adverse events or patterns during anesthesia regardless of administration site
- f) Other adverse events; for example, health care associated infections and infectious disease outbreaks

Measurable Elements of UNR-QPS.1

1. Leaders are committed to the adverse event reporting process.
2. The events to be reported include a) through f) in the Intent Statement,
3. The reporting process is implemented, and data are collected for events that meet the definition.
4. Adverse events that result in injury to a patient are reported hospital leaders.

Chapter 8 - Prevention and Control of Infections (UNR-PI)

Standard UNR-PI.1

One or more individuals oversee all infection prevention and control activities. This individual(s) should be qualified in infection prevention and control practices through education, training, experience, certification or licensure.

Intent of UNR-PI.1

The goal of a hospital's infection prevention and control program is to identify and to reduce the risks of acquiring and transmitting infections among patients, staff, and health care professionals.

Oversight of the infection prevention and control program corresponds to the hospital's size, complexity of activities and level of risks, as well as the program's scope. One or more individuals, acting on a full-time or part-time basis, provide that oversight as part of their assigned responsibilities or job descriptions.

Measurable Elements of UNR-PI.1

1. One or more individuals oversee the infection prevention and control program.
2. The individual(s) is qualified for the hospital's size, complexity of activities, and level of risks, as well as the program's scope.
3. The individual(s) fulfills program oversight responsibilities as assigned.
4. The program incorporates a range of strategies that includes systematic and proactive surveillance activities to determine usual (endemic) rates of infection.
5. The program includes systems to investigate outbreaks of infectious diseases.
6. Risk-reduction goals and measurable objectives are established and reviewed.

Standard UNR-PI.2

All patient and staff areas of the hospital are included in the infection prevention and control program.

Intent of UNR-PI.2

Infections can enter the hospital via patients, staff, volunteers, visitors, and other individuals, such as contracted workers. Thus, all areas of the hospital where these individuals are found must be included in the program of infection surveillance, prevention, and control.

Measurable Elements of UNR-PI.2

1. All patient care areas of the hospital are included in the infection prevention and control program.
2. All staff areas of the hospital are included in the infection prevention and control program.
3. All visitor areas of the hospital are included in the infection prevention and control program.

Standard UNR-PI.3

The hospital undertakes specific activities to establish the focus of the health care-associated infection prevention and reduction program.

Standard UNR-PI.4

The hospital tracks infection risks, infection rates, and trends in health care-associated infections to reduce the risks of those infections.

Intent of UNR-PI.3 and UNR-PI.4

The hospital has identified those epidemiologically important infections, infection sites, and associated devices, procedures, and practices that will provide the focus of efforts to prevent and to reduce the risk and incidence of health care-associated infections.

Hospitals collect and evaluate data on at least the following relevant infections and sites:

- a) Respiratory tract—such as the procedures and medical technology associated with intubation, mechanical ventilation support, tracheostomy, and so on;
- b) Urinary tract—such as the invasive procedures and medical technology associated with indwelling urinary catheters, urinary drainage systems, their care, and so on;
- c) Intravascular invasive devices—such as the insertion and care of central venous catheters, peripheral venous lines, and so on;
- d) Surgical sites—such as their care and type of dressing and associated aseptic procedures;
- e) Epidemiologically significant diseases and organisms, multi-drug resistant organisms, highly virulent infections; and
- f) Emerging or reemerging infections within the community.

The infection prevention and control process is designed to lower the risk of infection for patients, staff, and others. To reach this goal, the hospital must proactively identify and track risks, rates, and trends in health care-associated infections. The hospital uses measurement information to improve infection prevention and control activities and to reduce health care-associated infection rates to the lowest possible levels.

Measurable Elements of UNR-PI.3

1. The hospital has established the focus of the program through the collection of data related to a) through f) in the Intent Statement.
2. The data collected in a) through f) are analyzed to identify priorities for reducing rates of infection.
3. Infection control strategies are implemented to reduce the rates of infection for the identified priorities.

Measurable Elements of UNR-PI.4

1. Health care-associated infection risks, rates, and trends are tracked.

2. Processes are redesigned based on risk, rate, and trend data and information.
3. The hospital assesses the infection control risks at the time of each staff rotation.

Standard UNR-PI.5

The hospital reduces the risk of infections by ensuring adequate medical technology cleaning and sterilization, and the proper management of laundry and linen.

Intent of UNR-PI.5

Infection risk is minimized with proper cleaning, disinfection, and sterilization processes, such as the cleaning and disinfection of endoscopes and the sterilization of surgical supplies and other invasive or noninvasive medical technology for patient care. Cleaning, disinfection, and sterilization can take place in a centralized sterilization area, however the same standards should apply wherever they are performed in the hospital.

Measurable Elements of UNR-PI.5

1. Methods for medical technology cleaning, disinfection, and sterilization address the principles of infection prevention and control.
2. Methods for medical technology cleaning, disinfection, and sterilization are coordinated and uniformly applied throughout the hospital.
3. The principles of infection prevention and control are applied to laundry and linen management, including transportation, cleaning, and storage.

Standard UNR-PI.6

The hospital reduces the risk of infection through proper disposal of biomedical waste.

Intent of UNR-PI.6

Hospitals produce considerable amounts of waste each day. That waste is or could be infectious. Thus, the proper disposal of waste contributes to the reduction of infection risk in the hospital. This is true for the disposal of body fluids and materials contaminated with body fluids, body parts, and the disposal of blood and blood components. Because all staff may not be aware of which waste is or could be infectious, all biomedical waste must be disposed of in a uniform and safe way that protects the health care worker and the community.

Measurable Elements of UNR-PI.6

1. Disposal of infectious waste and body fluids is managed to minimize infection transmission risk.
2. The handling and disposal of blood and blood products are managed to minimize infection transmission risk.
3. Staff has guidance on proper disposal of infectious medical waste via incineration.
4. There is a uniform disposal process that includes all types of infection waste collection and proper disposal.

5. The infectious medical waste disposal process is part of the hospital's infection prevention and control process and is regularly evaluated and improved when indicated.

Standard UNR-PI.7

The hospital implements practices for safe handling and disposal of sharps and needles.

Intent of UNR-PI.7

One of the dangers of needle stick injuries is the possible transmission of blood-borne diseases. Incorrect handling and improper disposal of sharps and needles present a major staff safety challenge. Work practices influence the risk of injury and potential exposure to disease. Identifying and implementing evidence-based practices to reduce the risk of injury from sharps ensures that exposure to such injuries is minimal. Hospitals need to provide staff with education related to safe handling and management of sharps and needles.

Proper disposal of needles and sharps also reduces the risk of injury and exposure. Proper disposal includes the use of containers that are closable, puncture-proof, and leak proof on the sides and the bottom. Containers should be easily accessible to staff and should not be overfilled.

The hospital follows a policy that adequately addresses all steps in the process, including identifying the proper type and use of containers, the disposal of the containers, and the surveillance of the process of disposal.

Measurable Elements of UNR-PI.7

1. The hospital implements practices to reduce the risk of injury and infection from the handling and management of sharps and needles.
2. Sharps and needles are collected in dedicated, closable, puncture-proof, leak proof containers that are not reused.
3. The hospital disposes of sharps and needles safely to ensure the proper disposal of sharps containers in dedicated incinerators.

The hospital reduces the risk of infections associated with the operation of food services.

Intent of UNR-PI.8

The hospital must provide for the safe and accurate provision of food and nutrition products by ensuring that the food is stored and prepared at temperatures that prevent the risk of bacterial growth.

Cross contamination, particularly from raw foods to cooked foods, is another source of food infections. Cross contamination can result from contaminated hands, countertops, cutting boards, or cloths used to wipe countertops or dry dishes. In addition, the surfaces on which the food is prepared; the utensils, appliances, pots, and pans used for preparing food; and the trays, dishes, and utensils used for serving food can also be a risk for infection if not properly cleaned and sanitized.

Measurable Elements of UNR-PI.8

1. The hospital stores food and nutrition products using sanitation, temperature, light, moisture, ventilation, and security in a manner that reduces the risk of infection.
2. The hospital prepares food and nutrition products using proper sanitation and temperature.
3. Kitchen sanitation measures are implemented to prevent the risk of cross contamination.
4. The hospital has a process for the management of all staff, including kitchen staff who are symptomatically unwell.

Standard UNR-PI.9

Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, according to policy.

Intent of UNR-PI.9

Along with hand hygiene, barrier techniques are essential to any program to reduce the risk of infections in patients and staff. To be effective, the supplies must be available, readily accessible, used, and disposed of correctly.

Measurable Elements of UNR-PI.9

1. The situations in which barrier techniques are to be used have been identified and made known to staff.
2. Barrier techniques are used for identified situations, supplies are available and accessible, and the techniques are used correctly.
3. Surface disinfecting procedures are implemented for areas and situations in the hospital identified as at risk for infection transmission.
4. Surface disinfectants are used according to manufacturer instructions.
5. Soap, disinfectants, and towels or other means of drying are located in areas where hand-washing and hand-disinfecting procedures are required.

Chapter 9 - Governance, Leadership and Direction (UNR-GL)

Effective leaders dedicate themselves to continuous improvement through detailed knowledge of what is going on in their hospital, understand where assistance and/or oversight is needed, and monitor performance to required standards and regulations.

Standard UNR-GL.1

Leadership is structured to promote quality and patient safety.

Intent of UNR-GL.1

Clear and consistent leadership from the most senior leaders of the hospital is necessary for a culture of quality and safety. Without clear leadership, a culture of safety will not develop, and quality and patient safety will not be viewed as a hospital priority.

Measurable Elements of UNR-GL.1

1. The leaders for quality and patient safety have been identified.
2. The leaders are educated and trained on at least the basics of quality improvement principles, including measurement, aggregation and evaluation of clinical outcome data.

Standard UNR-GL.2

Leaders evaluate clinical outcome and admission data to support staff performance and track trends over time.

Intent of UNR-GL.2

Hospital leaders establish an ongoing process to collect data on issues identified as significant to patient safety. These may include the following, and others identified by hospital leaders:

1. Unplanned admissions to the ICU
2. Readmissions to the hospital following surgery
3. Average length of operating procedures
4. Recovery times for surgical procedures
5. Evacuation data, including diagnoses, frequency, precipitating events

Measurable Elements of UNR-GL.2

1. The hospital has a system in place to gather and track data for issues identified as significant to patient safety.
2. The data are specific to and are aggregated by at least: date, day, time, location, and staff member.
3. Appropriate (best practice when possible) upper and/or lower thresholds are determined to recognize variation.
4. Data gathering is ongoing.
5. When variations are noted outside of established thresholds, leaders investigate all contributing factors.

Chapter 10 - Facility Management and Safety (UNR-FS)

Overview

Hospitals are very complex places which house a significant amount of equipment, hazardous materials, and many types of patient supplies. Hospitals must take appropriate actions to ensure that they provide as protective and supportive environment as possible. Reducing environmental risks requires leadership commitment to safety, staff training, and regular inspection, maintenance, and monitoring.

Standard UNR-FS.1

The hospital facility and buildings are thoroughly inspected on a periodic basis to ensure awareness of risks that could affect patients and staff, and to plan for continuously improving the safety of the environment.

Intent of UNR-FS.1

The hospital is aware of the location, nature, and severity of its risks. This inspection covers a full range of potential risks, from broken or unstable furniture and locked or blocked fire exits, to faulty biomedical equipment and missing signs. There should be an effort to systematically reduce or eliminate those risks.

Measurable Elements of UNR-FS.1

1. The hospital has and implements a documented facility inspection plan to regularly, on an established schedule and/or when unsafe situations occur, to identify and list health care environment risks of all types.
2. Risks are identified in terms of severity and priority.
3. The risks identified are systematically reduced or eliminated, and the list is updated through periodic reinspections.

Standard UNR-FS.2

The hospital controls the use of hazardous materials.

Intent of UNR-FS.2

Hazardous materials include diagnostic and treatment materials, chemicals in the clinical laboratory, and caustic cleaning supplies. It is important to know the location of all hazardous materials and to manage the proper labeling, storage and handling of these materials. Spilled hazardous materials are reported, investigated and cleared in a manner that does not expose patients and staff to undue risk.

Measurable Elements of UNR-FS.2

1. There is a list of the location, type, and amount of hazardous materials within the hospital.
2. Based on the list, there is a plan for safe and proper labeling, storage, and use of hazardous materials
3. Spills and accidents involving hazardous materials are documented on incident reports.

4. Spills and accidents are investigated and measures are taken to prevent future incidents and/or improve the response to such spills and accidents.

Standard UNR-FS.3

There is a process in place to ensure that all occupants of the hospital are safe from fire, smoke and other emergencies.

Intent of UNR-FS.3

An effective approach to fire safety includes fire risk reduction, appropriate reaction when a fire occurs, and staff knowledge and training to ensure patients and staff can exit safely or move to safety in another part of the building.

Measurable Elements of UNR-FS.3

1. There is a fire safety program that includes prevention, early detection, abatement, and safe exit of staff and patients.
2. The program covers the entire hospital and is tested at least annually.
3. Results from annual testing are used to continuously improve the program through staff education.

Standard UNR-FS.4

There is an organized program for the safe management of biomedical equipment.

Intent of Standard UNR-FS.4

The safe use and maintenance of biomedical equipment is critical to the safety of patients and staff. Broken or unusable equipment can potentially compromise the diagnostic and treatment process for patients. Poorly maintained equipment may not give accurate results and frequent equipment breakdowns can delay needed tests, further compromising patient care.

Measurable Elements of UNR-FS.4

1. The hospital has a comprehensive inventory of all biomedical equipment.
2. The hospital has a program for inspecting, testing, and maintaining biomedical equipment by qualified individuals.
3. Equipment breakdowns are tracked, and data are used as part of the program to reduce the number of breakdowns.

Standard UNR-FS.5

Safe drinking water and electrical power are available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.

Intent of UNR-FS.5

Clean water is needed for many activities in a hospital, including sterilization and infection control. Similarly, electricity is needed to maintain the cold chain for medicines and blood and blood products

and to operate all types of equipment, including respirators, infusion pumps, and other life-maintaining equipment.

Measurable Elements of UNR-FS.5

1. There is a stable source of safe drinking water and electrical power for the hospital and
2. Alternate sources of safe drinking water and electrical power are available if the primary source is disrupted.

Chapter 11 - Management of Information (UNR-MI)

Standard UNR-MI.1

Information privacy, confidentiality, and security, including data integrity, are maintained.

Intent of UNR-MI.1

The hospital maintains the privacy and confidentiality of data and information and is particularly careful about preserving the confidentiality of sensitive data and information. The balance between data sharing and data confidentiality is addressed. Maintaining data integrity is an important aspect of information management. Policies and procedures address security procedures that allow only authorized staff to gain access to data and information. Access to different categories of information is based on need and decreed by job title and function. An effective process defines:

- who has access to data and information, including the medical record;
- the information to which an individual has access;
- the user's obligation to keep information confidential;
- the process for maintaining data integrity; and
- the process followed when confidentiality, security, or data integrity are violated.

Measurable Elements of UNR-MI.1

1. The hospital has a written process that protects the confidentiality, security, and integrity of data and information.
2. The process identifies the level of confidentiality maintained for different categories of data and information.
3. Those persons who need or have a job position permitting access to each category of data and information are identified.
4. Compliance with the process is monitored, and actions are taken when confidentiality, security, or data integrity are violated.

Standard UNR-MI.2

Records and information are protected from loss, destruction, tampering, and unauthorized access or use.

Intent of UNR-MI.2

Medical records and other data and information are secure and protected at all times. For example, active records are kept in areas where only authorized health care practitioners have access, and records are stored in locations where heat, water, fire, or other damage is not likely to occur. The hospital implements processes to prevent unauthorized access to electronically stored information.

Measurable Elements of UNR-MI.2

1. Records and information are protected from loss.
2. Records and information are protected from damage or destruction.
3. Records and information are protected from tampering and unauthorized access or use.

Standard UNR-MI.3

The medical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, and to document the course and results of treatment

Intent of UNR-MI.3

Information in the medical record must be as up to date as possible and contain all the patient information that is needed to provide appropriate care. The information in the medical record should be organized in a logical format, easily accessible, legible and complete.

Measurable Elements of UNR-MI.3

1. Patient medical records contain adequate information to identify the patient.
2. Patient medical records contain adequate information to support the diagnosis.
3. Patient medical records contain adequate information to justify the care and treatment.
4. Patient medical records contain adequate information to document the course and results of treatment.
5. Patient medical records contain adequate information to describe the discharge of the patient and any follow up care needed.
6. Patient medical records are organized in a logical, easily accessible format, legible and complete.

Standard UNR-MI.4

The hospital has a protocol regarding those who are authorized to make entries in the patient clinical record.

Standard UNR-MI.5

Every patient clinical record entry identifies its author and the time that the entry was made in the record.

Intent of UNR-MI.4 and UNR-MI.5

Access to information contained in the patient clinical record is based strictly on need and defined by job title and function. An effective process defines:

- who has access to patient clinical records;
- which information in the patient clinical record to which an individual has access;

- the user’s obligation to keep information confidential; and
- the process followed when confidentiality and security are violated.

One aspect of maintaining the security of patient information is to determine who is authorized to obtain a patient clinical record and to make entries into the patient clinical record. The hospital develops a policy to authorize such individuals. There is a process to ensure that only authorized individuals make entries in patient clinical records and that each entry identifies the author of the entry and the date. The policy must also include the process for how entries in the patient record are corrected or overwritten. The time of the entry is also noted, such as for timed treatments or medication orders.

Measurable Elements of UNR-MI.4

1. Those authorized to make entries in the patient clinical record are identified in hospital policy.
2. There is a process to ensure that only authorized individuals make entries in patient clinical records.
3. There is a process that addresses how entries in the patient record are corrected or overwritten.
4. Those authorized to have access to the patient clinical record are identified in hospital policy.
5. There is a process to ensure that only authorized individuals have access to the patient clinical record.

Measurable Elements of UNR-MI.5

1. The author can be identified for each patient clinical record entry.
2. The date of each patient clinical record entry can be identified.
3. The time of each patient clinical entry can be identified.