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THE ALBANIA PILOT HOSPITALS BASELINE SURVEY

TECHNICAL REPORT

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CONTENTS

ACRONYMS

EEHR	Enabling Equitable Health Reform
HII	Health Insurance Institute
HVAC	Heating, Ventilation and Air-Conditioning
MOH	Ministry of Health
NCQSA	National Center for Quality, Safety and Accreditation
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

USAID/Albania's Enabling Equitable Health Reforms (EEHR) project is a five-year project (2010-2015) to address the identified barriers and obstacles to more effective health policy and reform implementation in order to increase access to health services, particularly for the poor. EEHR is organized around three strategies to meet the goal of the project:

1. Improve capacities to implement a set of health reform interventions in selected sites;
2. Improve health reform policy and planning; and
3. Enhance non-state actors' participation and oversight of health systems performance.

EEHR will lead the implementation of a set of interventions in selected hospitals that fall under the six health systems strengthening building blocks of: Service Delivery, Health Workforce, Health Information Systems, Medical Products and Technology, Health Financing, and Governance. When implemented together, the interventions will test a holistic model for improving the organization and delivery of hospital services as a key component in improving overall health system performance and expanding access to health care services in the long term. For the purpose of this work plan, EEHR defines access as availability and coverage of needed services when consumers arrive at pilot hospitals. It is also envisioned that as regional hospitals improve their performance, access to regional services will be increased as fewer people self-refer to receive care in facilities in Tirana. The interventions will prepare pilot hospitals to be fully autonomous and test increased levels of hospital autonomy in one or more mature sites, providing a successful hospital governance model that may be replicated by the MOH and other hospitals in additional sites.

A hospital management specialist with extensive experience both in the United States and internationally was engaged to conduct three detailed, multi-day site visits to each of the selected pilot hospitals to analyze hospital operations using a hospital survey tool that the consultant designed organized around the six health system building blocks framework drafted by the World Health Organization. See Annex A: Hospital Baseline Survey Tool. At the end of each site visit, a translated copy of the Hospital Survey Tool was given to each Hospital Director. The directors were asked to complete all questions so that the EEHR team could understand how hospital management would assess themselves on basic management indicators. Based on the site visit findings and identification by the hospital management teams of their defined quality improvement priorities, a targeted action plan for interventions at each hospital to strengthen management weaknesses and enhance patient care was developed.

The three pilot hospitals, Queen Geraldina Maternity Hospital in Tirana, Korce Regional Hospital and Lezhe Regional Hospital all have significant management challenges and resource constraints. Many management problems are common to all facilities: weakness in Human Resource Management, a lack of reliable cost, utilization and clinical outcomes data, no organized, staffed quality improvement programs, pharmaceutical and medical supply chain management weaknesses, poorly functioning non-clinical services for which out-sourcing is a potential solution, no independent hospital governing board, and serious issues with bio-medical equipment repair and maintenance. Hospital management problems unique to each pilot hospital were also identified. Individual meetings with multiple members of the management team of each hospital were conducted and the consultant did an extensive tour of each facility stopping to talk with staff, observe patient care, inspect equipment, read patient records, walk through food service, laundry and plant maintenance support areas and note traffic flows, infection control and waste handling procedures. At all three pilot hospitals the EEHR team was met with strong support from the hospital directors who endorsed the project and insured a generous commitment of the management team's time and attention while the EEHR team was on-site.

Many management reforms will take a number of years to implement; others can be implemented in a very short time frame and have a significant impact without requiring a large investment of funds.

The focus of this effort was to develop an Action Plan for hospital management improvement initiatives that identify Short Term (6 Month) Multi-Hospital and Individual Hospital changes that can be rapidly introduced with EEHR staff and hospital management team support and will have a measurable positive impact on hospital operations.

This report includes a summary of Finding Highlights from the three selected pilot hospitals and is followed by a Year Two Action Plan for Hospital Management Improvements.

1. BACKGROUND

USAID/Albania's Enabling Equitable Health Reforms (EEHR) project is a five-year project (2010-2015) to address the identified barriers and obstacles to more effective health policy and reform implementation in order to increase access to health services, particularly for the poor. EEHR is organized around three strategies to meet the goal of the project:

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This consultancy was requested by USAID, through the contractor, Abt Associates, Inc., and supports Strategy 1: Improve Capacities to Implement a Set of Health Reform Interventions in Selected Sites as fully detailed in the Work Plan Activities for Year Two of the Enabling Equitable Health Reforms Project in Albania. Three hospitals were selected for a detailed hospital operations review by the consultant during this trip. From the on-site observation of both clinical and non-clinical service delivery components, human resources management, and interviews with management team members an action plan for each hospital for interventions to improve management and operations has been developed for approval by the respective hospital directors.

A hospital management specialist with extensive experience both in the United States and internationally was engaged to conduct three detailed, multi-day site visits to each of the selected pilot hospitals to analyze hospital operations using a hospital survey tool that the consultant designed organized around the six health system building blocks framework drafted by the World Health Organization. See Annex A: Hospital Baseline Survey Tool.

2. OBJECTIVES

The primary objective of this consultancy was to conduct three detailed site visits to the selected pilot hospitals to analyze hospital operations using a hospital survey tool organized around the six health system building blocks. Based on the site visit findings and identification by each of the hospital management teams of their quality improvement priorities, a targeted action plan for interventions at each hospital to strengthen management weaknesses and enhance patient care would be developed. This plan would become a road map for EEHR and partner activities in the coming years of the project to support implementation of health reform and improved operations in the pilot hospitals.

3. APPROACH AND METHODS

The consultant, Ms. Myers, worked under the guidance of Chief of Party Julian Simidjiyski and in close collaboration with EEHR staff all of whom provided invaluable insight, background information and logistical support throughout the consultancy. Before embarking on the field work, Ms. Myers conducted an extensive review of Government of Albania documents, EEHR and other donor project reports, and Albanian and internationally sourced hospital operations management resources, templates and tools. See Annex B for the list of documents reviewed. The in-country work was carried out from February 20 – March 7, 2012 and involved the following activities:

- Multi-day detailed operational reviews of the selected three pilot hospital sites:
  - Queen Geraldine Maternity Hospital – Tirana
  - Korce Regional Hospital
  - Lezhe Regional Hospital

  These assessments were conducted using a hospital survey tool. See Annex A for the hospital survey tool. At the end of each site visit, a translated copy of the Hospital Survey Tool was given to each Hospital Director. The directors were asked to complete all questions so that the EEHR team could understand how hospital management would assess themselves on basic management indicators.
- Attendance at the EEHR Project Meeting with the Health Reform Implementation Support Group at which agreement was reached on selection of pilot hospital sites
- Visits to Mother Theresa Hospital (Tirana) and Durres Hospital for additional perspective on the hospital sector organization and management
- Meetings with the National Center for Quality, Safety and Accreditation, Ministry of Health officials, USAID, the Integrated Telemedicine and e-Health Program of Albania, the Health Insurance Institute (HII) and the World Bank for background information
- Debriefing with USAID/Tirana.
- Based on the site visit findings and identification by the hospital management teams of their defined quality improvement priorities, a targeted action plan for interventions at each hospital to strengthen management weaknesses and enhance patient care was developed.

4. FINDINGS

4.1 QUEEN GERALDINA MATERNITY HOSPITAL –

(Site Visit Dates: February 21-22, 2012)

4.1.1 KEY FINDINGS:

A very significant factor that makes the Queen Geraldina Maternity Hospital in Tirana the pilot hospital with the most likely potential for great success is its history as a participant in the USAID Twinning Project over a decade ago. Queen Geraldina was twinned with the Rhode Island Women's and Infants Hospital in Providence, Rhode Island. Despite the fact that the Twinning project ended in 2002, the two hospitals have maintained a close relationship and collaboration and learning continues to enrich and benefit the Albanian maternity hospital. Queen Geraldina senior managers were most recently in Rhode Island in April 2011. When asked what was the greatest learning that the Deputy Director for Finance and Administration took away from that trip, his answer was the need for the Queen Geraldina staff to focus work on Human Resources Management improvements. The hospital's lack of detailed, hospital-specific job descriptions, a new employee orientation program and a well-structured and regularly administered employee performance review program is recognized as a significant management weakness.

Throughout Albania there is a noted on-going effort to significantly increase the skills of hospital nurses and greatly increase the professional status of nurses in the healthcare system. Historically the job of hospital cleaning has been the responsibility of the Nursing Department; hospital cleaners are supervised by nurse managers. There is strong support at Queen Geraldina to champion the western hospital model of separating the cleaners from the Nursing Department structure and establishing an independent Department of Environmental Services that is lead by a manager professionally trained in hospital infection control, the proper selection and use of hospital cleaning equipment and supplies, scheduling, and employee training techniques. It is noted that the establishment of an organizationally separate department will facilitate the effort to out-source the management of this non-clinical service in the near future.

4.1.2 ADDITIONAL FINDINGS:

1. Food Service – This is an out-sourced service. Three hospitals in Tirana have out-sourced their food service.
2. Laundry – There is no separation of infectious linen during the cleaning process. Linen soiled with blood, urine and feces from infectious patients is mixed with all other patient linen in the collection and cleaning process which could result in an increased risk of infection.
3. Sanitary Services – There is no special staff training, no equipment standards, and staff is using standard household cleaning supplies.
4. Fire Safety – There have been no fire drills; there is a lack of disaster planning.
5. Equipment Maintenance – Repair of bio-medical equipment is very difficult. The existence of equipment from many different manufacturers increases the problem. The standard is only one year maintenance contracts which results in having to negotiate annual price increases. The hospital does not have a preventive maintenance schedule.

   There is a National Center for Medical Equipment Maintenance that trains bio-medical engineers, but graduates tend go to private companies after graduation.
6. Medication Administration Records – This is a real problem. It is currently difficult to determine if an ordered medication has actually been given to the patient. A new IT system will address this.

7. Infection Control – This is a priority for hospital management. Currently there is a problem with the availability of antibiotics and laboratory capacity for comprehensive surveillance.
8. Incident Reporting – There is a register on the wards to record errors, but this data is not tracked for trend identification and design of Quality Improvement initiatives.

4.2 KORCE REGIONAL HOSPITAL

(Site Visit Dates: February 28-29, 2012)

4.2.1 KEY FINDINGS:

The Hospital Director identified the lack of adequate data for making good management decisions as his greatest challenge. He is extremely interested in capturing good data and in the use of Information Technology to improve the management function of the hospital.

Currently there are four separate registration logs with significant overlap. Every patient who enters through the emergency unit is registered. If the patient is admitted to the hospital, he is re-registered in the in-patient registration log. If the patient is admitted to a 24-hour observation unit he is re-registered there as a short-stay patient. If it is determined that a short-stay patient needs in-patient care, he is registered a third time as an in-patient. Finally, there is a registration log for patients seen by the ambulance service who are not brought into the hospital.

A significant amount of redundant paperwork would be avoided with an automated patient registration and discharge system. But more important, the hospital will be able to track patients through the system and have accurate data on emergency patient triage decisions.

A second key management issue is a significant accountability gap in the pharmaceutical supply chain in the hospital. Closing this gap will increase the ability to trace any loss of drugs from the system and will provide patient specific medication administration records which are a required component of a quality assurance program that monitors for medication errors. Currently drugs that are issued by the pharmacy to the patient units are tracked. However, once reaching the unit, there are no patient-specific medication administration records on which the nurse records and verifies with signature the specific medication, dose, day and time administered.

4.2.2 ADDITIONAL FINDINGS:

1. Secondary Income – Secondary income is decreasing. This is causing significant strain on the budget.
2. Training – Management is working on identifying clinical training needs.
3. Hospital Accreditation – The hospital is just getting started on looking at hospital accreditation standards.
4. Equipment – Equipment maintenance is a large problem. Example: New endoscopy equipment donated by the World Bank was damaged by a nurse using an improper sterilization procedure. The equipment was thus not covered by the warranty. More than 8000 Euros are needed for repair. The hospital is not able to cover this expense. The result is that patients now have to go to Tirana, and no the hospital has no capacity to handle emergencies. Other pieces of broken equipment include a large radiology unit and a Blood Protein Analyzer.
5. Human Resources –
    - Turn-over rate extremely low
    - Hospital Director signs off on every hiring decision
    - In the past two years only one person was fired
    - There is a three-month probationary term evaluation and an annual performance evaluation
    - There is no training for non-clinical staff; The hospital has a mentoring system that matches a new employee with an experienced worker in the same position
    - There is no general hospital orientation for new hires
    - There are no detailed job descriptions for each position; the general duties for a position are

described in the employee's employment contract

6. Laundry – Out-sourcing tendering procedures have begun for the laundry service. The current facility cannot handle the washing of patient blankets between patients. Laundry machines are very old, some are not working, the water temperature is not adequate for hospital laundry requirement, some linen was observed to be line-drying in the snow due to a lack of dryer capacity.
7. Food Service – There is a plan to out-source this service, but the tendering process has not yet begun.
8. HVAC – There is a new central heating system that uses oil; this is very expensive. The hospital depleted its oil supply mid-February and is currently rationing a supply procured with a promissory note.
9. Operating Room – There are four well-equipped operating theaters for scheduled surgery and one large, two-table room for emergency surgeries. At 10:00am Tuesday morning there was not a patient in the operating suite or in the pre-operative/post-operative recovery room. Financially this has significant impact as generally the operating suite is a primary revenue source for a hospital.
10. Radiology – There is no digital radiology capacity in the hospital. There was a huge line of out-patients waiting for sonography studies because of the lack of sonography equipment at the polyclinics. The Chief of Radiology indicated that he has sufficient staff (3 radiologists and 5 technicians) to cover the polyclinics and decompress an unmanageable load at the hospital, but the equipment limitations prevent this from happening.
11. Visitor Control - The hospital needs a visitor control system. There is no limitation of the number of visitors a patient is allowed at any one time; two-bed rooms were observed crowded with 8-10 visitors crowding the room preventing either patient the chance to rest and increasing the risk of infection.
12. Patient Transfers to Tirana – Currently there is no system for learning the outcome of a patient transferred from Korce Regional Hospital to Tirana. The patient is discharged from Tirana with a discharge summary that is taken back to the primary care doctor, but the referring hospital receives no feedback.
13. Medical Records – There are separate physician records and nursing records. Information from the physician record is copied into the nursing record. The two are not merged until patient discharge. The nursing record was a major innovation piloted in 2000 and fully implemented in 2003.

    In only an estimated 5-10% of cases do doctors request that a patient's previous hospital admission records be pulled from the archives when a patient is admitted to the hospital.
14. Intensive Care Unit – There is no ability to isolate an infectious patient.
15. Maternity Hospital –
    - There were four in-patients in the Maternity Hospital at the time of this visit. There are two well-equipped delivery rooms and two c/section procedure rooms. All were empty. One post-partum patient whose baby had been transferred to Tirana was present and three gynecology in-patients. The infrastructure maintenance cost and staffing cost for the patient volume was extreme.
    - Equipment needs were identified as a major challenge. There was broken colposcopy equipment.
    - Medical records and registration are separately maintained from the main hospital.
    - Patient flows are inefficient; after a c/section or gynecology procedure, a patient is admitted to a recovery room for approximately 24 hours and again is transferred to a regular patient unit bed after that. For uncomplicated cases the patient could be transferred directly to a regular unit reducing the nursing transfer procedure time and staffing for the post-operative observation ward.

- Laundry – The maternity hospital laundry is in deplorable condition. The equipment is barely functioning; the walls are crumbling from accumulated moisture, the laundry staff does not have a detergent product that properly cleans the linens. Out-sourcing is urgent.

4.3 LEZHE REGIONAL HOSPITAL

(Site Visit Dates: March 1-2, 2012)

4.3.1 KEY FINDINGS:

The hospital is very interested in out-sourcing Laundry, Food Service, Grounds Maintenance and Transport Services. They are in the process of tendering grounds maintenance and transport services for patients needing dialysis in Tirana. The Food Service and Laundry Service are in desperate need of up-grading and out-sourcing would improve service quality. There is great concern, however, that the current budget for these services will not cover the cost of purchasing these services from the private market. For example, the Director of Finance indicated that the current cost of food per patient/per day is approximately $2.00. Provision of three nutritional meals per day by a professional company is anticipated to cost significantly more. Similarly, the Director of Finance does not believe that an outside laundry service can provide clean linen within the current hospital budget for linen and laundry service. Assisting the hospital with a more thorough analysis of out-sourcing options may discover a viable option. Issues that need to be considered include:

- Both the food service and laundry need significant capital improvements if they are to be run on-site by a private company. Is operation of the services off-site at a private company owned and managed facility an option?
- The current hospital staffing levels are high in general. Can reduction in staffing costs help off-set an increased budget allocation for food and laundry services?
- There is no separation of infectious linen. A hidden cost of this practice is a likely increase of unreported nosocomial infections.
- There is no proper dishwashing capability in the hospital food service department. Nurses and patient's families are washing dishes and utensils on the nursing units, but it was reported that there is a lack of hot water and thereby an inability to properly clean kitchen ware.
- Removing responsibility for hospital cleaning from the Nursing Department and creating a separately managed, professionalized, properly trained hospital environment services department will facilitate out-sourcing.

The hospital Deputy Director for Finance and Administration identified as a priority the need for a central Store Room function to improve the pharmaceutical and medical supplies chain management. Currently there are five locations where pharmaceuticals and medical supplies are stored and inventoried at the hospital. Developing one centrally managed warehouse would improve efficiency and decrease staffing needs. Additional improvements in supply chain management such as the introduction of quarterly rather than annual procurement need analysis.

The Human Resources Department at Lezhe Hospital is only one year old. Department leadership is very interested in management improvements. Introducing the Management Sciences for Health "Human Resource Management Rapid Assessment Tool for Health Organizations" will assist the department in development of its Human Resources Management function. Areas noted for improvement include the development of detailed job descriptions, a new employee orientation, and an annual performance evaluation program.

4.3.2 ADDITIONAL FINDINGS:

1. Unit Secretary – A simple staffing modification that converts one nursing position to a "Unit Secretary" would increase nursing employee satisfaction and increase the amount of clinical care time on the nursing units. A Unit Secretary position would be responsible for maintaining the unit patient registration log, assembling the pharmacy requisition order, and performing other administrative tasks as assigned that currently take a huge amount of nursing management time.

Utilizing the most highly skilled clinical nurses to fulfill hours of secretarial work decreases the capacity of the hospital to improve clinical patient care.

2. Nurse Staffing - Currently nursing management does not have the authority to adjust nursing assignments based on clinical needs and patient occupancy levels between nursing units. For example, the orthopedic unit may have a very low census and the Intensive Care Unit be at 100% occupancy, but excess nursing capacity on orthopedics cannot be temporarily shifted to the ICU, even for a couple of hours in the event of a cardiac arrest/resuscitation in the ICU. Giving this authority to the Director of Nursing would more effectively allocate clinical nursing resources to match patient care needs.
3. Visitor Control - The lack of effective Visitor Control is a significant infection prevention and control issue. During visiting hours an unlimited number of visitors crowd around patient beds, wander throughout the hospital, enter procedure rooms and interrupt patient care. Instituting for all hospitals a two-person maximum visitor control policy with a sign-in and pass system will significantly decrease pedestrian traffic throughout the hospital, improve infection prevention and control and provide improved privacy and resting conditions for patients in multi-bed patient rooms.
4. Incident Reporting System – The introduction of a required Incident Reporting System for any unusual occurrence that involves any patient, staff member or visitor will begin to provide hospital management with quality improvement data. An Incident Reporting system, while difficult to implement, is a significant tool for beginning to change the culture of a healthcare institution from one that hides errors or accidents to one that uses information about such occurrences to address areas where patterns of problems exist. It is recognized that currently medical errors and hospital acquired infections are not reported for follow-up.
5. Surgery Waiting Area – Currently there is no waiting area for family whose relative is in the Operating Suite. The result is crowds of people filling the corridors of the surgical patient care unit waiting for information about the outcome of a case. Again, this is poor infection control practice and interrupts nursing care on the unit. A family waiting area should be identified off the surgical patient unit and a policy enforced that visitors and family are not allowed to congregate outside patient rooms.
6. Group Purchasing Consortium – Organizing a group purchasing consortium of the twelve regional hospitals would significantly increase order volumes and theoretically result in decreased pricing for pharmaceuticals and medical supplies. Similarly, bidding of equipment maintenance contracts as a group should theoretically result in significantly more favorable terms in regards to response time, available bio-medical equipment professional staffing capability to cover the regions and pricing.
7. Medical Records – Currently there is a separate medical record for patients admitted from the Emergency Unit to a 24-hour Observation Unit that is not integrated with the medical record for an observation patient who is subsequently admitted to an in-patient unit. Demographic and treatment information is hand copied from one to the other, or lost; the records are separately archived and there is a different record retention policy for the two charts. When a patient is admitted as an in-patient from the Observation Unit, a consolidation of the patient records would improve continuity of care and decrease administrative paperwork.
8. Operating Room Suite:
    - The hospital is at risk of having to close its entire operating room function if the one operating autoclave malfunctions. There are two autoclaves; one is not functioning. The other is a new unit, just past its one-year warranty period, but no equipment maintenance contract was purchased for this current fiscal year. The equipment is showing signs of needing maintenance. This is an extremely high priority item that needs attention.
    - There is only one anesthesiologist on staff. Three are needed.
    - There is no air filtration in the Operating Theaters. There is no budget to purchase filters.
    - There is no air circulation/recommended air exchanges per hour.

- There is only 10 cases average per week for two theaters. With fully functioning equipment, efficient environment services capability for room turn-over, and good scheduling, this volume could be handled in one day.
- There are regular shortages of some needed supplies such as sutures.

9. Nursing Unit Management:
   - Supply shortages of drugs, gloves, cleaning disinfectants were identified
   - Patient equipment (i.e. patient gurney) was noted as needing cleaning
   - A lack of hot water on the unit and a lack of any shower/bathing facilities results in nurses not being able to adequately bath patients.

   Note: A solar hot water heating system was recently installed. It does not appear to be adequately supplying hot water to the patient care units.
   - Small washing machines were installed on the patient units. They are often broken or inadequate to clean patient linen. Drying linen is a significant problem. Blankets are often damp when needed for patients.
   - There are no screens on the windows to prevent flying insects from entering patient care areas.
   - The only special diet that the food service is able to provide is a modified breakfast menu for diabetic patients.
10. Medical Waste Management:
    - Only sharps are being separated, placed in special sharps containers and handled as medical waste. These are collected and transported to Tirana for disposal in patient ambulances. There is no other separation of medical waste (bloody bandages, discarded used supplies from the infectious disease unit, etc.).
    - There was an incinerator built on the hospital grounds but neighborhood objections and air pollution issues shut it down.
11. Infection Control – This was identified by the Hospital Director (who is a surgeon) as his top priority.

Other priorities identified were auditing admitting diagnoses with discharge diagnoses to improve utilization of established clinical practice protocols and monitoring the use of antibiotics in the hospital.

5. RECOMMENDATIONS

Many of the operational problems identified during the three pilot hospital site visits were common for all the hospitals. The clearest example of this is weakness in the Human Resources Management function of the hospitals where development of five broad areas, human resources capacity, personnel policy and practice, human resources data, performance management, and training is lacking or non-existent. Similarly, all pilot hospitals have reported some procedure for Incident Reporting, but a comprehensive Incident Reporting System that swiftly gathers information on any untoward occurrence that affects a patient, employee or visitor, tracks and trends that data and then incorporates the findings into the institution's quality improvement program planning was absent.

Other findings from the site visits identified potential action items specific to the circumstances in a single pilot hospital such as a specific space utilization pattern that is having significant consequences on an important operational process.

The Year Two Project Action Plan (below) divides the short-term action plan items into Multi-Hospital initiatives and Single Hospital initiatives. It is important to note that it is the intention of the project to develop the successful implementation of many of the single hospital initiatives as models which will subsequently be extended into the regional hospitals.

6. EEHR YEAR TWO ACTION PLAN - PILOT HOSPITAL INITIATIVES

ACTIVITIES	PARTICIPANTS	OUTPUT	M	A	M	J	J	A	S
Multi-Hospital - Short Term Initiatives									
1. Human Resources Management Improvement **Health Systems Building Block – Human Resources**									
1.1 Research government regulations and practices that control hospital Human Resource management practices	EEHR	List of barriers	X						
1.2 Conduct one day training in HR Management for pilot hospital management teams	EEHR, Hosp Management Team	Knowledge of Stages of HR Components and Development Stages Training curricula developed and delivered.		X					
1.3 Complete HR Management Rapid Assessment Tool	Hosp Management Team	Written Assessment Report Completed		X					
1.4 Provide EEHR Technical Assistance for development of New Employee Orientation Program Comprehensive Job Descriptions for all Employees Annual Performance Evaluation Program	EEHR, Hospital HR Manager	Orientation Program, Job Descriptions and Performance Evaluation tool developed			X	X	X		
2. Incident Reporting System **Health Systems Building Block – Service Delivery**									
21. Introduce Incident Reporting System	EEHR, Hosp	Incident Report Form;		X					

	Management Team	Policies & Procedures for Incident Reporting							
2.2 Train all hosp supervisory staff on Incident Reporting	HR Manager, Department Heads, Chief of Service	Increased knowledge of tool for Quality Improvement. QI training curricula developed and conducted.			X	X			
2.3 Incorporate Incident Reporting in Employee Orientation and begin the use of Incident Reports	HR Manager	Orientation meetings and practical training of Incident Reporting Program delivered to all employees					X		
2.4 Implement the use of Incident Reports for trend analysis of quality and risk management issues	Hosp Director, Quality Improvement Officer	Reports to Hosp Management and QI Committee					X		
3. Visitor Control Program **Health Systems Building Block – Service Delivery**									
3.1 Develop policies and procedures for visitor control	EEHR, Hosp Management Team	Written Visitor Control Guidelines		X					
3.2 Design a Visitor Control Card and Visitor Access Control Station	EEHR, Hosp Mgmt	Control Card and access control point			X				
3.3 Identify and train employees to staff the Visitor Access Control Station	HR Manager	Training curricula on Improved Infection Prevention and Security developed and conducted.				X			
4. Out-Sourcing Non-Clinical Services Management Training **Health Systems Building Block – Service Delivery**									
4.1 Research current regulations, review previous studies, and document current pilot hospital out-sourcing	EEHR	Data base of current pilot hosp contracts		X					

4.2 Conduct one-day training on Out-Sourcing of Non-Clinical Services – The Role of Hospital Management	EEHR, Hospital Management Team	Knowledge of contract administration- hosp mgmt responsibility Training curricula developed and training conducted.				X			

Single Hospital – Short Term Initiatives

5. Queen Geraldina Maternity Hospital - Establishment of an Environmental Services Department

Health systems Building Block – Service Delivery

5.1 Re-draw the hospital Organization Chart to establish a new Department of Environmental Services	Hospital Management Team	New hospital departmental structure		X					
5.2 Identify cleaning staff to transfer from the Dept of Nursing to the Dept of Environmental Services	HR Manager, Head Nurse	Environmental Services staff roster		X					
5.3 Identify candidates for Department Manager and Supervisors	HR Manager	Dept leaders appointed			X				
5.4 Identify and provide professional training program for department manager and supervisors on: • Infection Control in Hospitals • Scheduling methodologies • Patient equipment cleaning • Proper use of cleaning equipment and cleaning chemicals • Good supervision practices	HR Manager, Environmental Services manager and supervisors	Knowledge of professional standards and techniques; use of equipment and chemicals; scheduling methodologies; and employee training requirements. Training curricula developed and training conducted.				X			
5.5 Train all Environmental Services employees	ES Manager, Supervisors, all staff	Training curricula developed and training conducted. All employees trained; Performance expectations established				X	X		

5.6 Conduct research on potential vendors for out-sourcing management of the new Environmental Services Department	EEHR, Hospital Management	List of potential vendors						X	
5.7 Develop tender for service Out-Sourcing	EEHR , Hospital Management	Tender Offer							X
6. Queen Geraldina Maternity Hospital – Establishment of a Hospital Governing Board **Health Systems Building Block - Governance**									
6.1 Provide professional consultation on the Development, Appointment and Training of an independent hospital governing Board of Directors	EEHR, Hosp Dir	Hosp Board and Hosp Director defined roles and responsibilities		X	X				
6.2 Identify potential candidates for the Board of Directors	MoH, HII, Hosp Dir,	List of candidates for board appointment			X				
6.3 Provide Board training for selected members	EEHR, Board of Directors	Written Guidelines for Hospital Governing Board Roles and Responsibilities				X	X		
6.4 Formal appointment and first meeting of Hospital Governing Board	Board of Directors	Agenda and Minutes of First board meeting							X
7. Korce Regional Hospital – Nurse Medication Administration Record **Health Systems Building Block – Medical Products Management**									
7.1 Develop a Patient Medication Administration Record	EEHR, Head Nurse, Chief Pharmacist	Patient Administration Record		X					
7.2 Write Policies and Procedures for the use of the Patient Medication Administration Record	EEHR, Head Nurse, Chief Pharmacist	Written policies and procedures		X					
7.3 Train all nursing and pharmacy staff on the use of the Patient Administration Record – Implement use of the record	Nursing/Pharmacy management, All nursing and pharmacy staff	Training documented in all nursing/ pharmacy personnel files			X	X			
7.4 Develop Medical Record audit procedures to confirm proper use of the Patient Medication Administration Record	EEHR, Head Nurse, Chief Pharmacist	Written audit procedures					X		
7.5 Develop Pharmacy audit procedures to verify pharmacy unit issue records with drug usage using the Patient Medication Administration Record	EEHR, Chief Pharmacist	Written audit procedures						X	

7.6 Conduct pharmacy audit	Chief Pharmacist	Reconciliation report							X
8. Lezhe Regional Hospital - Establishment of a Central Warehouse **Health Systems Building Block – Medical Products Management**									
8.1 Catalogue current space locations and allocation for pharmaceutical and medical supplied	EEHR, Dir of Finance	Space inventory		X					
8.2 Identify space needs and location for a centralized medical supplies Store Room – Prepare Room	EEHR, Dir of Finance	Space allocated for new function		X	X				
8.3 Conduct training for Store Room staff on the Storage of Essential Medicines and Other Health Commodities	EEHR, Store Room Manager and staff	Written Guidelines for Store Room Management				X			
Mid-Term Initiatives (12-24 Months)									
9. Automated Patient Registration and Discharge **Health Systems Building Block – Health Information Systems**									
10. Pharmaceutical Supply Chain Strengthening **Health Systems Building Block - Medical Products Management**									
11. Out-Sourcing of Hospital Laundry Service **Health Systems Building Block – Service Delivery**									
12. Strengthening Hospital Capacity for Bio-Medical Engineering and Maintenance of Medical Equipment **Health Systems Building Block – Service Delivery**									
13. Comprehensive Hospital Space Utilization Review **Health Systems Building Block – Health Financing**									
14. Establishment of a Hospital Governing Board at Korce and Lezhe Regional Hospitals **Health Systems Building Block - Governance**									

Long-Term Initiatives (12-36 Months)
15. Development of a Hospital Five Year Strategic Plan Health Systems Building Block - ALL
16. Implementation of Modules of a Hospital Information System Health Systems Building Block – Health Information Systems
17. Assist with the Implementation of Cost per Case Financial Tracking and Monitoring Health Systems Building Block – Health Financing

ANNEX A – ASSESSMENT TOOL

HOSPITAL BASELINE SURVEY TOOL[1]

HOSPITAL:_____ **Date:**_____
Location: _____

Main Contact Person: _____
Medical Director: _____
Total Number of Beds in Use (# in use/total # of beds in facility)_____
Average Daily Census (Inpatients)_____
Does the hospital have a

Strategic Plan	Yes_____ No_____
Organization Chart	Yes_____ No_____
Incident Reporting Tracking System	Yes _____ No _____
Quality Improvement Plan	Yes _____ No _____

1. HEALTH SYSTEM BUILDING BLOCK – HUMAN RESOURCES

	INDICATOR	YES	NO	REMARKS
1.1	The hospital has a formal HR Department that handles all employee matters			
1.2	The HR Director is a member of the senior management team			
1.3	Job Descriptions exist for all positions			
1.4	There is a unique employment record or folder for each employee			
1.5	There is a New Employee Orientation Program for all employees			
1.6	The hospital has on-going training and development programs for employees			
1.7	Training Records are maintained and up-to-date			[1]
1.8	The hospital has a Performance Management Program with annual employee evaluations that include documented action plans for improved performance indicators			
1.9	The HR Department documents manpower shortages and has corresponding recruitment plans			
1.10	The HR Department has an operations manual that			

[1] Adapted from baseline assessment used for Ethiopia Hospital Management Initiative – Yale University/Clinton Foundation Partnership, 2006.

	includes policies for:			
a	Hiring Procedures			
b	Work Scheduling			
c	New Employee Orientation			
d	Compensation			
e	Benefits			
f	Payroll Information			
g	Workplace Injuries			
h	Performance Review/Evaluation			
i	Confidentiality of Personnel Records			
j	Progressive Disciplinary Actions			

2. HEALTH SYSTEM BUILDING BLOCK – SERVICE DELIVERY

INDICATOR		YES	NO	REMARKS
NON-CLINICAL SERVICES				
Environmental Services				
2.1	There is a separate Environmental Services Department with an experienced Director			
2.2	The department is out-sourced			
2.3	There is an employee training program that standardizes procedures and use of chemical cleaning agents			
2.4	There are detailed work area assignments and schedules			
2.5	There are adequate cleaning supplies and equipment			
2.6	Multi-disciplinary rounds are made weekly by clinical and housekeeping managers			
Laundry				
2.7	There is a separate Laundry Department with a trained laundry/linen manager			
2.8	The department is out-sourced			
2.9	There is a linen inventory management system			
2.10	There are written procedures for handling of infectious linen			
2.11	There is a linen/laundry cost per patient day tracking system			
Food Service				
2.12	There is a hospital kitchen managed by a trained food service director			
2.13	The department is out-sourced			
2.14	There are professional dieticians on staff			

2.15	There is a system for ordering and preparing special diets			
2.16	There is a food procurement and inventory management system			
2.17	There is a food cost/patient day tracking system			
Safety				
2.18	There is a fire safety plan, evacuation routes are visibly posted and fire drills are conducted regularly			
2.19	There are written internal and external disaster plans that are regularly reviewed with the staff			
2.20	The department is outsourced			
2.21	The disposal of hazardous waste is monitored for adherence to written policies			
Security				
2.22	The department Is out-sourced			
2.23	There is a system for tracking property loss			
Facilities Maintenance				
2.24	There is a facilities maintenance department directed by a professional facility manager			
2.25	The Facilities Maintenance Department is outsourced			
2.26	There is a written preventive maintenance schedule that is regularly followed			
2.27	There is potable water available 24 hours/day 7 days/week through regular or alternate sources to meet essential patient care needs			
2.28	There are building systems failure procedures for:			
a	Oxygen			
b	Medical Air			
c	Vacuum			
d	Nitrous Oxide			
e	Electrical Supply			
f	Water Supply			
g	Telephone			
Patient Registration and Referral				
2.29	There is a consistent procedure for the proper registration of a patients			
2.30	There are regular quality audits to assure that complete patient registration information is obtained.			
2.31	There are written criteria and procedures for the referral of patients to another facility			
2.32	A feedback loop been established that tracks and monitors referrals			
CLINICAL SERVICES				
Bio-Medical Equipment				

2.33	There is a comprehensive inventory of all medical equipment			
2.34	There is a bio-medical equipment preventive maintenance plan for all medical equipment			
2.35	The work is out-sourced			
2.36	There are regular training programs for staff using medical equipment			
2.37	Equipment warranties and service agreements are tracked			
Medical Records Management				
2.38	Each patient has a unique medical record number			
2.39	The registration system is unified for in-patient and out-patient records			
2.40	There are written medical record documentation standards			
2.41	There is a uniform set of forms that comprise a complete medical record			
2.42	There are routine medical records quality audits			
2.43	There are written procedures for the proper handling, storage and confidentiality of medical records			
Nursing Standards and Practice				
2.44	There is a clear nursing department management structure			
2.45	The roles and responsibilities for licensed and unlicensed staff are clearly differentiated			
2.46	There are standard nursing admission procedures and an admission assessment that includes:			
a	Reason for Admission			
b	Current and Past Medical History			
c	Current Medications			
d	Psychological Factors			
e	Home and Family Factors			
f	Physical Functioning			
2.47	Within 24 hours of admission and nursing Plan of Care is filed in the patient medical record and progress notes required for each shift			
2.48	A Medication Administration Record for each patient is maintained and audited daily by a nursing supervisor			
2.49	Nursing progress notes are recorded for each shift			
2.50	There is a formal nurse-to-nurse report at the end of each shift			
2.51	There are written patient transfer and discharge protocols			
Quality Assessment/Improvement				
2.52	There is a functioning Quality Improvement			

	Committee chaired by a senior manager			
2.53	An overview of the Quality Improvement program is part of every employee's orientation			
2.54	Quality audits are routinely completed and reported to the governing board			
2.55	Incident Reports are tracked for trends and used to define quality improvement initiatives			
2.56	Continuous feedback of quality improvement efforts is part of the organizational culture			
Infection Prevention and Control				
2.57	There is a written hospital infection prevention and control plan			
2.58	There is an Infection Prevention and Control Committee chaired by the individual charged with overseeing the Infection Control program			
2.59	The hospital follows Universal Precautions			
2.60	There are department specific infection prevention and control policies			
2.61	The hospital laboratory is capable of supporting the infection control surveillance activity			
2.62	There is training on infection control for every member of the hospital staff			
2.63	Essential equipment and supplies are available in all patient care areas			
2.64	There are infection control policies and procedures for:			
a	Patient and visitor control			
b	Staff hand hygiene and dress control			
c	Transmission-based precautions			
d	Post-exposure prophylaxis			
e	Isolation room assignments			
f	Environmental Services cleaning procedures and use of chemicals			
g	Medical Waste Management			
2.65	There are sinks with running water available in all clinical areas			
2.66	There is soap or an alcohol-based hand rub available			
2.67	Clean and Dirty items are stored separately			
Emergency Services				
2.68	There is a separate Emergency Services entrance with a centralized triage function			
2.69	There is a patient registration capability in the Emergency Department			
2.70	There are policies and procedures for isolating infectious patients in the Emergency Services area			
2.71	There are written procedures for patient admission to an in-patient unit from the Emergency			

	Department			
Laboratories				
2.72	There is adequate equipment and supplies to meet the clinical needs of the hospital			
2.73	Laboratory equipment is routinely calibrated and a complete record of test results are on file			
2.74	Laboratory personnel are trained to follow standard operating procedures to ensure reliable test results			
2.75	Routine quality assessments are conducted to ensure reliability of test results			
2.76	There are defined turn-around times for each test and written procedures for reporting results			
2.77	The laboratory work environment is kept organized and clean with safe procedures for handling specimens and waste material			
SERVICE RATIONALIZATION				
2.78	The hospital has established a local implementation team to lead work on the Hospital Rationalization Plan			
2.79	Development of a plan for each clinical service has begun:			
a	Priority for development of sub-specialties			
b	Equipment needs based on sub-specialty priorities			
c	Staffing needs for all clinical services			
d	Training needs to develop the sub-specialties			
e	Plan for rotation of specialists to Primary Care Centers			
f	The hospital has written referral protocols			

3. HEALTH SYSTEM BUILDING BLOCK – MEDICAL PRODUCTS MANAGEMENT

INDICATOR		YES	NO	REMARKS
PHARMACY				
3.1	There is a hospital Pharmacy and Therapeutics Committee that monitors adherence to an approved formulary			
3.2	There is a Pharmacy Manual that includes policies and procedures on:			
a	Drug ordering			
b	Dispensing from central pharmacy			
c	Nursing unit storage and dispensing			
d	Proper and safe disposal of expired drugs			
e	Narcotics controls			
f	Inventory control system			
MEDICAL STORES				
3.3	There is an approved list of medical supplies and par			

	inventory levels			
3.4	There is adequate storage facilities (clean, proper temperature, ability to manage stock rotation)			
3.5	There is a unit distribution system that records usage by unit			
SUPPLY CHAIN MANAGEMENT				
3.6	There are written Procurement policies and procedures on:			
a	Ordering Guidelines (quality, stock quantities, competitive bidding procedures)			
b	Maximum/Minimum stock levels			
3.9	Supplier contracts, back-up sources and guaranteed delivery time frames are documented			
3.10	There is a clean receiving area and written procedures for placement of supplies into inventory			

4. HEALTH SYSTEM BUILDING BLOCK – GOVERNANCE

INDICATOR		YES	NO	REMARKS
4.1	There is a hospital governing board			
4.2	The governing board meets regularly and minutes of meetings are recorded			
4.3	The governing board membership includes representatives of the community			
4.4	The hospital executive director is selected by, reports to, and is annually evaluated by the hospital governing board			
4.5	There are established performance indicators for the hospital that are regularly monitored by the governing board			
4.6	The board annually reviews and approves the hospital budget			

5. HEALTH SYSTEM BUILDING BLOCK – HEALTH FINANCING

INDICATOR		YES	NO	REMARKS
5.1	The hospital has annual and monthly operating budgets for each department or clinical service			
5.2	There are agreed upon indicators for budget performance that are regularly tracked and reported to the hospital governing board			
5.3	The hospital collects and reports volume statistics tracked over time			
5.4	The hospital produces a monthly:			
a	Income Statement			
b	Statement of Cash Flow			
c	Balance Sheet			
d	Budget Variance Report			

e	Sources of Revenue Report			
5.5	The hospital has the capability of developing cost-per-case statistics			
5.6	The hospital has written policies and procedures for:			
a	Billing			
b	Credit			
c	Collection			

6. HEALTH SYSTEM BUILDING BLOCK – HEALTH INFORMATION SYSTEM

INDICATOR		YES	NO	REMARKS
6.1	There is a hospital IT development plan			
6.2	The hospital has electronic information systems for:			
a	Patient Registration			
b	Accounting/Financial Reporting			
c	Electronic Medical Record			
d	Medical Supply Management			
e	Pharmacy			
f	Laboratory Results Reporting			
g	Radiology Results Reporting			
h	Human Resources Management			
6.3	The hospital has in-house staff expertise to manage its electronic data systems			
6.4	Initial and on-going staff training is provided for employees using electronic systems			
6.5	The hospital uses electronically captured information in its quality improvement program			
6.6	The hospital is able to electronically report to the MoH health status indicator data			
6.7	Written policies and procedures exist for:			
a	Protection of patient privacy			
b	Retention of records			
c	Verification of data quality (accuracy, completeness timeliness)			
d	System security			

HOSPITAL MANAGEMENT TEAM	
Who are the members of the management team?	
How often does the management team meet?	

Are minutes of management team meetings recorded?	
Hare you or any members of the management team had formal hospital administrations training?	
If yes, Where? How long? Subjects covered?	
Has this training been helpful for your work now?	
What kinds of additional training would you like to have?	

ANNEX B – DOCUMENT REVIEW

Government documents:

Albania (Draft) Health System Strategy, 2007 to 2013 (March 2007)

2009 Health Sector Performance Report

2011 Health Sector Activity Map

2010 Health Sector Milestone Report

Durres Hospital Contract

Hospital Accreditation Standards

Laws and regulations:

Law No. 10 107 of 30.3.2009 Health Care in the Republic of Albania

Law No. 9106 of 17.7.2003 Hospital Service in the Republic of Albania

EEHR Project Reports:

Cashin, Cheryl. July 15, 2011. T*he Albania Health Sector Monitoring and Evaluation Function, Technical Report.* Bethesda, MD. Enabling Equitable Health Reform Project in Albania, Abt Associates Inc.

Chee, Grace and Joanne Jeffers, July 15, 2011. *The Albania Health Sector Governance Study, Technical Report.* Bethesda, MD. Enabling Equitable Health Reform Project in Albania, Abt Associates, Inc.

Enabling Equitable Health Reforms Project in Albania. October 14, 2011. *First Annual Report – FY2011.* Bethesda, MD. Enabling Equitable Health Reforms Project in Albania, Abt Associates, Inc.

Enabling Equitable Health Reforms Project in Albania. January 24, 2012. *Second Year Work Plan.* Bethesda, MD. Enabling Equitable Health Reforms Project in Albania, Abt Associates Inc.

Enabling Equitable Health Reforms Project in Albania. January 30, 2012. *DRAFT Regional Assessment Report.* Bethesda, MD. Enabling Equitable Health Reforms Project in Albania, Abt Associates Inc.

Joanne Jeffers, October 17, 2011. *Identifying Priority Areas for Health Reform Implementation, Technical Report.* Bethesda, MD. Enabling Equitable Health Reforms Project in Albania, Abt Associates, Inc.

Purvis, George, Ainura Ibrahimova, and Flora Hobdari, July 15, 2011. *Albania Health Insurance Institute Review: Challenges and Opportunities, Technical Report.* Bethesda, MD. Enabling Equitable Health Reform Project in Albania, Abt Associates Inc.

Other Donor and Project Reports:

"Developing Hospital Performance Analysis Capacity," Inception Report for the HII in Albania, Patrice Korjenek (June 2009)

"Report on New Model of Governance and Financial Autonomy, selected for both Hospitals and PHC Centers", EPOS Consultants, Albania Ministry of Health/ World Bank Health System Modernization Project, Technical Assistance for Framework for Provider Autonomy (March 2008)

"Report including Recommendations for Improving Legal Framework" EPOS Consultants, Albania Ministry of Health/ World Bank Health System Modernization Project, Technical Assistance for Framework for Provider Autonomy (June 2008)

Terms of Reference and Scope of Services "Reforming Hospital Payment in Albania" (International Technical Assistance) Health System Modernization Project (P082814) and Japanese Grant, World Bank, C.3. Implementation of Hospital Governance

World Bank Project Appraisal Document: Health System Modernization Project, Albania (2006)