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# Joint Commission International

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A partnership between the Joint Commission on Accreditation of Healthcare Organizations and its consulting subsidiary Quality Healthcare Resources, Inc.  
September 15, 1997

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Ms. Susan Matthies  
ENI/HR/HP  
US Agency for International Development  
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Dear Ms. Cleland and Ms. Matthies;

Re: Trip Report—Romania

JCI consultants, Carole Fink, RN, MSN, MBA (February 5-14, 1997) and Hubert T. Gurley, MD, MPH (February 3-14, 1997), provided technical assistance in standards field testing and surveyor training in Romania.

The attached trip report covers the objectives, work activities/accomplishments, conclusions, and issues and recommendations, which will be used for planning subsequent program activities. Kindly review the reports and please feel free to call me (630-268-7444) if you have any questions.

Sincerely,

Deborah L. Fuller, MHSA, CPHQ  
Manager of International Projects

cc: James F. Janeski, Executive Director  
Carole Fink, RN, MSN, MBA, Consultant  
Hubert T. Gurley, MD, MPH, Consultant

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**ACCREDITATION PROGRAM  
FOR CEE COUNTRIES**

**ROMANIA**

**TRIP REPORT  
February 3 - 14, 1997**

**Prepared by: Carole Fink, RN, MSN, MBA  
Hubert T. Gurley, MD, MPH**

**Submitted to: AID/EUR/HR/HP  
Agency for International Development  
23rd and C Streets, NW  
Washington DC 20523-0053**

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## **Objectives**

The objectives of the consultation visit were to work with the Accreditation Council and members of the standards advisory committee to:

1. Provide training to two groups of surveyors. (One group had previously participated in the introductory module and was to receive a more advanced module in preparation for survey participation. The other group was to receive the introductory module which is to be followed by the advanced module at a later time.)
2. Conduct two mock surveys, one day each in two hospitals.
3. Develop an accreditation decision-making mechanism.
4. Develop a mechanism for reporting and communicating survey results.

## **Background and General Comments**

The USAID-JCI cooperative effort with the Romanian Hospital Association to develop standards leading to an accreditation capability is underway with six standards nearing completion. Four standards are in various stages of development. A computerized methodology for scoring and accreditation decision data collection utilizing Microsoft Excel has been developed. Five of the standards were broken into scorable elements and incorporated into the computerized format. Relative weights and scoring "caps" were discussed and reviewed. Thirty-two physicians and nurses representing nearly every geographic region of Romania and various professional groups participated in a two and one half day course to:

- learn about the components and rationale of an accreditation system and the role and activities of surveyors;
- identify sources of information required to score five of the standards; and
- address questions concerning each of the standards.

Twenty-one hospital evaluators who had participated previously in the introductory evaluator training module held in October, 1996 returned for the advanced module to further participate in survey process, review draft standards and to actively participate in two one-day hospital mock surveys.

As there had been a change in government and ministers of health since the time of the last visit four months earlier, little progress had been made with regard to the recommendations at the conclusion of the last visit. There had been minimal activity of the accreditation committee. Refinement and development of standards had come to a halt. There exists no permanent staff or regular meetings of the accreditation committee. However, the individuals involved in the accreditation initiative, including representatives of the Ministry of Health expressed continued enthusiasm for the

accreditation initiative. A methodology for the computerized scoring of standards and generating data necessary for accreditation decision making was proposed and implemented. Standards for Nursing, Infection Control, Management of Information, Environment of Care, Emergency Department, were incorporated into this format. The format includes identification of the sources of information, relative weights and arithmetic manipulation to provide standard specific and chapter summary data as a basis for accreditation decision making. Two groups of evaluators (surveyors) attended one of the two-day educational sessions at the introductory or advanced level. A template for survey process was developed, distributed and discussed. Templates for pre-survey hospital orientation, survey schedules, pre-survey demographics, medical record review and human resources data review were shared and discussed. Mock surveys were conducted in Carol Davila Teaching Hospital of Nephrology and Bagdosar University Emergency Hospital.

The consultative visit began with two days of work group activity with the staff of the accreditation committee in their offices. The review included an update on the activities of the accreditation activities in Romania and a review of work that had been accomplished by the accreditation committee and staff since the on-site visit in October of 1996.

### **Standards Development**

The Standards Committee had not met to further the process of standards development and approval since the consultation visit of October, 1996. Several sets had not been translated and others await development.

Dr. Gurley and Dr. Sava spent several days dividing approved standards into measurable elements. During the same time, Ms. Fink was directing educational sessions for new surveyors, and for surveyors who had previously participated in the initial surveyor training.

The rubric for categorization of standards introduced during the consultant visit of October, 1996 was continued during the definition of measurable elements:

- A = Logical yes or no response;
- B = Qualitative - use of a qualitative descriptor in the assessment; and
- C = Quantitative - use of a quantitative measure of performance.

As a result of much discussion regarding the application of this categorization, it was clear that some standards needed to be clarified and split into multiple standards to provide greater clarity and measurement in the accreditation process.

The classification of sources continued to follow the previously introduced rubric as well:

- DR = Document Review;
- HR= Human Resource Record;
- PR = Personal or Medical Record of Patient;
- WI = Interview with Staff of Ward or Unit;
- WO = Observation on Ward or Unit;
- LI = Interview with Leaders;
- PI = Patient Interview.

This categorization was used to determine the logical sources of gathering information related to the survey during the actual survey. It was noted this becomes an important part of the development of the survey process, in training surveyors in the accreditation process, and also in instructing organizations being accredited. This approach and review of the daughter standards await review by the standards committee.

The concept of standards weighting and capping was explored in detail. Criteria for weighting were suggested as follows:

- giving greater weight to actions versus policies;
- giving greater weight to standards that most directly relate to patient care or patient safety;
- giving greater weight to standards that contained several component issues;
- giving less weight to standards that were not typically being accomplished in Romanian hospitals; and
- giving greater weight to standards that relate to Romanian law or regulation.

Capping relates to the difficulty of achieving compliance at the present, but sets the expectation for future performance. The mathematical model was discussed in detail. It is easily incorporated into Excel software. This methodology awaits approval by the standards committee.

### **Activities**

A three-day educational program (Module 1) was held on February 5-7, 1997. There were 32 participants, including 26 participants who had been selected as hospital evaluators. Participants were attentive, and asked excellent questions. There was good discussion about the six standards that had been translated into Romanian (Patient Rights, Environment of Care, Nursing Service, Information Management, Emergency Services, and Infection Control). Ms. Fink taught most of the program while Dr. Gurley worked on scoring standards with Dr. Sava.

On the third day, Dr. Novac gave an update on activities at the Ministry of Health, including:

- Finalizing the first 10 standards and scoring activities for each;
- Developing protocols for evaluation of each of the 10 standards;
- Training at least one team of evaluators for each county;
- Obtaining a critical mass of supporters if this progresses (Parliament, Ministry of Health, Local Health Authorities, Hospitals, Professional Organizations, Patients, and Media);
- Pushing forward for a law or an act recognizing the accreditation program and supporting implementation; and
- Continuously communicating among countries that adopt accreditation.

Dr. Novac also discussed threats to the program including the change of the ministerial team (Dr. Dop, a strong supporter of the accreditation program, has recently resigned) and delays in drafting laws. She also discussed the possibility that all European countries (Hungary, Poland, and Czech Republic) investigate this model assemble for a meeting in October, 1997.

In addition, the plan is to use Romanians as trainers after two groups complete the full training of three weeks.

On Saturday February 8, 1997, Dr. Gurley and Ms. Fink met with members of the Accreditation Committee to discuss the Patient Rights and Governing Body standards. However, the group deferred the discussion on Patient Rights standards and focused on the Governing Body/Management standards. There was much discussion on the relationship between these standards and laws in development. There is no Romanian word for "policy" also, management structure and functions need to be defined by law before standards can be approved.

A two-day educational program (Module 2) was held on February 10-11, 1997. There were 21 participants, all of whom had attended the October, 1996 program. Ms. Fink taught most of the program, while Dr. Gurley continued to work on scoring standards with Dr. Sava.

### **Issues and Recommendations:**

The in-country USAID coordinator will be leaving Romania within several weeks. The continuation of the project requires the naming of another individual to this position who can provide much needed coordination and continuity.

Existing and proposed standards must be approved and promulgated to interested parties before additional training can be provided to evaluators in their application and use in the accreditation process. Intensive review of standards by the Accreditation Council is necessary to move this process forward.

The following recommendations from the visit of October, 1996 still require review and implementation:

1. Determine the required sequence of events and time frame for survey of interested hospitals.
2. Finalize the process of making accreditation decisions.
3. Determine the mechanism for communication of survey results.
4. Establish a formal standards approval process and supporting legislation to provide the directive required for implementation.
5. Trial the approved standards in additional hospitals as a further test of their value and use.

Supporting infrastructure of the Accreditation Council must be developed and implemented. Required elements include:

1. Identification of funding for a permanent office for the proposed Accreditation Council to include dedicated personnel, equipment and space. (This is essential for the success of the effort.)
2. Determination of the standing membership of the Accreditation Council to include representation by the MOH, professional associations, the public and others.
3. Enabling legislation to support accreditation activities and implementation. Support for accreditation activities must be encouraged through educational activities provided to hospitals, professional associations, members of Parliament and the citizens of Romania.

## **APPENDIX A**

### **Preliminary Trip Report**

Central Eastern Europe Accreditation Program  
Preliminary Report for Romania  
Visit of JCI Consultants:  
Carole Fink, RN, MSN, MBA (5 Feb to 14 Feb, 1997)  
&  
Hubert T. Gurley, MD, MPH (3 Feb to 14 Feb, 1997)

#### **Visit Objectives**

- a. To provide training to two groups of surveyors. One group has previously participated in the introductory module and is to receive a more advanced module in preparation for survey participation. The other group is to receive the introductory module which is to be followed by the advanced module at a later time.
- b. Two mock surveys are to occur, one day each in two hospitals.
- c. A decision making mechanism is to be developed.
- d. A mechanism for reporting and communicating survey results is also to be developed.

#### **General Comments**

The USAID-JCI cooperative effort with the Romanian Hospital Association to develop standards leading to an accreditation capability is underway with six set of standards nearing completion. Four additional sets are in various stages of development. A computerized methodology for scoring and accreditation decision data collection utilizing Microsoft Excel was developed. Five of the standards sets were broken into scorable elements and incorporated into the computerized format. Relative weights and scoring "caps" were discussed and reviewed. Thirty two physicians and nurses representing nearly every geographic region of Romania and various professional groups participated in a two and one half day course to learn about the components and rationale of an accreditation system and the role and activities of surveyors; to identify sources of information required to score five sets of standards; and to address questions concerning each of the standards. Twenty-one hospital evaluators who had participated previously in the introductory evaluator training module held in October, 1996 returned for the advanced module to further participate in survey process, to review draft standards and to actively participate in two one day hospital mock surveys.

For reasons which include a change in government and ministers of health since the time of the last visit four months earlier, little progress had been made with regard to the recommendations at the conclusion of the last visit. There had been minimal activity of the accreditation committee.

Refinement and development of standards had come to a halt. There exists no permanent staff or regular meetings of the accreditation committee.

However, the individuals involved in the accreditation initiative, including representatives of the Ministry of Health expressed continued enthusiasm for the accreditation initiative. A methodology for the computerized scoring of standards and generating data necessary for accreditation decision making was proposed and implemented. Standards for Nursing, Infection Control, Management of Information, Environment of Care, Emergency Department, were incorporated into this format. The format includes identification of the sources of information, relative weights and arithmetic manipulation to provide standard specific and chapter summary data as a basis for accreditation decision making. Two groups of evaluators (surveyors) attended one of two two-day educational sessions at the introductory or advanced level. A template for survey process was developed, distributed and discussed. Templates for pre-survey hospital orientation, survey schedules, pre-survey demographics, medical record review and human resources data review were shared and discussed. Mock surveys were conducted in Carol Davila teaching hospital of nephrology and Bagdosar University Emergency Hospital.

#### **Issues and Recommendations:**

1. The in-country USAID coordinator will be leaving Romania within several weeks. The continuation of the project requires the naming of another individual to this position who can provide much needed coordination and continuity.
2. Existing and proposed standards must be approved and promulgated to interested parties before additional training can be provided to evaluators in their application and use in the accreditation process. Intensive review of standards by the Accreditation Council is necessary to move this process forward.
3. The following recommendations from the visit of October, 1996 still require review and implementation:
  - Determine the required sequence of events and time frame for survey of interested hospitals.
  - Finalize the process of making accreditation decisions.
  - Determine the mechanism for communication of survey results.
  - Establish a formal standards approval process and supporting legislation to provide the directive required for implementation.
  - Trial the approved standards in additional hospitals as a further test of their value and use.
4. Supporting infrastructure of the Accreditation Council must be developed and implemented. Required elements include:
  - Identification of funding for a permanent office for the proposed Accreditation Council to include dedicated personnel, equipment and space. This is essential for the success of the effort.

- - Determination of the standing membership of the Accreditation Council to include representation by the MOH, professional associations, the public and others.
  - Enabling legislation to support accreditation activities and implementation.
5. Support for accreditation activities must be encouraged through educational activities provided to hospitals, professional associations, members of Parliament and the citizens of Romania.

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## APPENDIX B

### Guide to the Hospital Survey Process

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## **Opening Conference**

The opening conference is a meeting between key organization staff and surveyors on the first day.

### **Purpose:**

- To introduce surveyors to key organization staff and to discuss the survey agenda.

### **Who Will Participate?**

From the organization:

- Director (Head of organization);
- Economic Director (or person responsible for finances);
- Person responsible for maintaining building services;
- Chief Nurse (or nursing representative);
- other persons at the discretion of the Director; and
- All Surveyors.

### **What Documents Need To Be Available?**

Survey application.

Organization demographics (e.g., census information, description of services offered, number and types of units).

## **ASSESSMENT PHASE**

### **Leadership Interview**

During the Leadership Interview, the surveyors interview senior leaders in a group meeting.

#### **Purpose:**

- To learn about the organization and major issues affecting operations.
- To assess organizational structure and methods of communication.
- To start to assess organization's approach to patient rights standards.
- To start to assess organization's approach to improving quality of care.

#### **Who will Participate?**

From the organization:

- Director (head of organization);
- Economic Director (person responsible for finances);
- Person responsible for maintaining building services;
- Chief Nurse (or nursing representative); and
- other persons at the discretion of the Director.

All Surveyors.

#### **What Documents Need To Be Available?**

Survey application.

Organization demographics (ex. census information, description of services offered).

Information about building inspections and elevator maintenance.

Written plan regarding prevention of losses due to disasters (ex. Fire, loss of electricity).

Records relating to identification of building code deficiencies and plans for reducing major deficiencies.

Records relating to training staff about the fire safety plan.

Records relating to preventative maintenance of all medical equipment.

**Example Questions.** (Abbreviations following the questions are listed in Appendix B). The following questions start to gather information about compliance with the standards. Additional information will be gathered during other survey activities. Questions should be open-ended (i.e. not able to be answered with a "yes" or "no" response) in order to encourage participation.

How do hospital staff get the information they need to do their jobs? (LD)

What are the established lines of authority and responsibility? (LD)

How do you make decisions about spending available funds? (LD)

How do you make decisions regarding staffing different units? (LD, HR)

How have you considered patient rights in your hospital? (RI)

How are patients informed of their rights? (RI)

How have you improved quality of care in your hospital? (PI)

How have you responded to major building issues (ex. lack of running water, heating problems, generator problems)? (EC)

How do you monitor and trend nosocomial infections? (IC)

How do you evaluate patient satisfaction or dissatisfaction with care provided? (PI)

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## ASSESSMENT PHASE

### Visits to Hospital Departments

Visits to hospital departments are major activities in the survey process. During the visits, compliance to many standards can be evaluated in some way. During the visits, the surveyors will observe patient care activities, speak with members of hospital staff, speak with patients, and review patient records. The surveyors will also be able to make observations about environment of care (ex. Are the building and surroundings safe for the patients and staff? Are activities performed to minimize the spread of infection? Are the emergency escape doors easily identified and unobstructed?)

If it is not possible for surveyors to visit all units/departments, the surveyor will select the visits based on risk to the patient. For example, Operating Rooms and Intensive Care are departments where high risk activities take place.



## Emergency Services Visit

During the emergency services visit, the surveyor assesses the setting where emergency services are performed and compliance with relevant standards.

### Purpose:

- To address standards related to emergency services.
- To address standards related to patient rights, physical assessment, continuity of care, environment of care, and human resources (adequate and competent staff).

### Who Will Participate?

From the organization:

- Physicians involved in the delivery of emergency services;
- Nurse involved in caring for patients in emergency services; and
- others at the discretion of the Director.

Physician Surveyor.

### What Documents Need To Be Available?

Medical records of patients receiving emergency services.

### Example Questions.

How is physician coverage provided? (HR)

How do you evaluate the required skills of the nursing staff? (HR)

How do you provide for increasing the skills of the nursing staff? (HR)

How do you assess patients to determine the best unit or setting for them to receive care? (CC)

What are your criteria for referral and transfer? (CC)

What documentation in the medical record is required before discharging or transferring a patient?  
(CC, IM)

What would you do in case of power failure? (EC)

How are instruments cleaned and stored between use?

How long does it take for a patient receive appropriate lab and radiology services?

How long does it take for the results to be available to the physician? (IM)

### Example Observations.

Is the environment established to provide for patients' privacy? (RI)

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Are staff caring for patients in a way that would minimize infections (ex. handling of infectious wastes)? (IC)

Are emergency medications and supplies available? (COP)

Is fire equipment available? (EC)

Are emergency exits clearly marked? (EC)

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### **Inpatient Units Visit**

During the visits to the inpatient units, the surveyors assess settings where patient care is delivered and compliance to relevant standards.

#### **Purpose:**

- To address standards related to patient rights, physical assessment, information management, continuity of care, environment of care, and human resources (adequate and competent staff).

#### **Who will Participate?**

From the organization:

- Physicians and nurses available on the unit; and
- others at the discretion of the Director.

Either Surveyor.

#### **What Documents Need to Be Available?**

Information related to patient infections.

Medical records of patients on the unit.

Evacuation plans.

Policies related to medication administration.

Policies related to documentation on the medical record.

#### **Example Questions.**

How are staff educated about fire plans and other safety plans (ex. utilities failure)? (EC)

How are patients involved in obtaining informed consent prior to surgery? (RI)

How are patients given information about their care and procedures/ tests? (RI)

What information is obtained during the initial patient assessment? When is the information documented in the medical record? (PE, IM)

How often are patients reassessed by the physician after admission? By the nurse? (PE,IM)

How do you evaluate the required skills of the nursing staff? (HR)

How do you provide for increasing the skills of the nursing staff? (HR)

How do you adjust staffing when the patients require more nursing care than usual? (HR)

What documentation in the medical record is required before discharging or transferring a patient? (IM)

How is care provided to the patient who has a terminal illness? (RI)

How do you plan for nursing care? (NR)

**Example Observations.**

Is the environment established to provide for patients' privacy? (RI)

Are patient care procedures (such as bathing) performed in a manner that respects privacy? (RI)

Are medications given to patients recorded? (IM)

Are staff caring for patients in a way that would minimize infections (e.g. handling of infectious wastes)? (IC) What about staff in food preparation areas? (IC)

Is food delivered in a safe, accurate, timely, and acceptable manner?

If patients are restrained, is there documentation of adequate justification and documentation consistent with established laws? (COP, RI)

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### **Kitchen (or food preparation areas) Visit**

During the visits to the kitchen and/or food preparation areas, the surveyor assesses compliance to relevant standards.

#### **Purpose:**

- To address standards related to infection control and to the environment of care.

#### **Who Will Participate?**

From the organization:

- Staff from these areas; and
- other at the discretion of the Director.

Nurse Surveyor.

#### **Example Questions.**

What is your role in case of a fire? (EC)

How do you wash and prepare food? (IC)

How do you know if food is spoiled? (IC)

What illnesses would you report to your supervisor? (IC)

What would you do if running water was not available? (EC)

#### **Example Observations.**

Is the area clean? (IC)

Do staff perform activities to minimize transmission of infection? (IC)

Are there fire extinguishers available? Are they in working order? Do staff know how to use them? (EC)

### Laboratory Services Visit

During the laboratory services visit, the surveyor assesses relevant standards.

#### Purpose:

- To assess compliance to standards with an emphasis on the integration of the laboratory in the hospital's activities and how these activities are coordinated with other departments.
- To evaluate the environment of care, especially as it relates to safety.

#### Who will Participate:

From the organization:

- Physician responsible for the operation of the laboratory ; and
- others at the discretion of the Director.

Physician surveyor.

#### What Documents Need to Be Available?

Quality control data.

Records relating to equipment maintenance and operations.

#### Example Questions.

How do you know the lab testing that you are doing is accurate? (PI)

If the lab testing is done elsewhere, how do you know those results are accurate? (PI)

How do you know your equipment is functioning properly? (PI)

How do you know the staff are performing in a competent manner? (HR)

How have you improved the services you provide? (PI)

What would you do in case of a fire? Where is fire equipment (i.e. extinguishers, hose) located?  
(EC)

Can you operate the fire equipment? (EC) Ask staff to tell or show you how equipment works.

#### Example Observations.

Is the area clean and free of clutter? (EC)

Are staff performing in away that would minimize infections? (e.g. handling of infectious wastes)  
(IC)

Are the emergency exits easily identified and free of obstruction? (EC)

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## Operating Room Visits

During the operating room visits the surveyor assesses those areas where surgery is performed and anesthesia is given.

### Purpose:

- To address standards related to patient rights, physical assessment, environment of care, and infection control.

### Who Will Participate?

From the organization:

- Physicians involved in performing surgery;
- Nurses providing care to those patients; and
- others at the discretion of the Director.

Nurse Surveyor.

### Example Questions.

How are patients involved in obtaining informed consent prior to surgery? (RI)

What happens if the patient does not want surgery? (RI)

How are patients assessed prior to and during surgery? (PE)

How are patients monitored during anesthesia and during surgery? (COP, IM) Is there documentation? (IM)

Is any information required on the record before surgery can be done? (IM)

What information is written on the chart after surgery? (IM)

How do you know if the equipment is functioning properly? (EC)

How would you handle a power failure during surgery? (EC)

What types of emergency drugs and supplies are available in the operating room? (COP)

### Example Observations.

Is a preoperative diagnosis recorded before surgery is done? (IM)

Are staff performing in a way to minimize infections? (IC)

Is the area clean? (IC)

Are patient care procedures performed in a manner that respects privacy? (RI)

### **Pharmacy Visit**

During the pharmacy visit, the surveyor observes the conditions under which medications are prepared and interviews the staff who prepare, dispense, and monitor medications.

### **Purpose**

- To assess storage and preparation processes for medications.

### **Example Questions.**

How do you know what medications are available in the hospital? (COP)

What emergency medications are available? How are they controlled? (COP)

What is the plan if there is no power, and certain drugs must be refrigerated? (COP)

### **Example Observations.**

Are there policies for medication administration? (COP)

## **Radiology Visit**

During the radiology visit, the surveyor assesses the settings where diagnostic radiology procedures are performed

### **Purpose**

- To assess standards related to patient rights, environment of care, infection control, and continuity of care.

### **What Documents Need to be available?**

Quality control data.  
Records relating to equipment operation.

### **Example Questions.**

How long does it take between the time a radiology study is ordered and the time the results are available? (COP, IM)

How do you know your equipment is functioning properly? (PI)

How do you know your staff are performing in a competent manner? (HR)

What would you do in case of a fire? Where is fire equipment located? (EC)

How would you obtain emergency drugs and supplies? (COP)

### **Example Observations.**

Are patient care procedures performed in a manner that respects privacy? (RI)

How are patients informed about procedures?

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### **Sterile Processing/ Decontamination Area Visit**

During the visit the surveyor observes the conditions and process for sterile processing/ decontamination (i.e. the area where used patient care equipment and instruments are washed and prepared to be used again).

#### **Purpose:**

- To address standards related to infection control.

#### **Example Questions.**

How do you clean equipment and instruments when they are soiled? (EC)

How do you know if equipment is functioning properly? (IC)

What do you do if you are cut with dirty equipment or splashed in the eyes while washing the equipment? (IC)

#### **Example Observations.**

Is the area clean? (IC)

Are staff performing in a way to minimize infections?



### Medical Record Review

During the medical record review, the physician surveyor assesses compliance to standards related to documentation.

#### Purpose:

- To address standards related to physical assessment and information management.

#### Who Will Participate?

From the organization:

- Physicians;
- Nurses;
- others who make entries in the medical record; and
- others at the discretion of the Director.

Physician Surveyor

#### What Documents Need To Be Available?

Medical records requested by the surveyor.

Policies and procedures related to medical record documentation.

#### Example Questions.

How is the privacy of the patient medical record assured? (IM)

How could you locate a medical record when the patient returns to the hospital? (IM)

How long does it take to get a past medical record? (IM)

How does the patient receive access to the medical record? (RI)

What is the policy about telephone or verbal orders? (IM)

How soon after a patient's transfer or discharge must the medical record be completed? (IM)

#### Example Observations.

Is the following information included in the medical record: (IM)

- patient identification data : name, birth date, address, contact person, patient's ID number (or unique medical record number);
- physician assessment and history or illness done within 24 hours of admission;
- informed consent to surgery and risky procedures;
- diagnosis and therapeutic recommendations of the physician;
- a nursing plan for care;

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- a record of medications given and patient response to those medications;
- final conclusions and recommendations.

Are the medical records kept in a location that protects them from damage or loss? (IM)

Are the medical records confidential? (IM)

Is there a nursing plan of care for each patient? (NR)

Is there a medical plan of care for each patient? (COP, IM)

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## Nursing Interview

During the nursing interview, the surveyor assesses the organization of nurses and relevant standards.

### Purpose:

- To address standards related to nursing services provided in the hospital.

### Who Will Participate?

From the organization:

- Chief Nurse (if one has been designated);
- nurses to represent different units; and
- others at the discretion of the Director.

Nurse Surveyor

### What Documents Need To Be Available?

Documentation of nursing qualifications and on-going education.

Policies and procedures relating to documentation in the medical record by nurses.

### Example Questions.

What type of training is given to a newly hired nurse? (HR)

How do nurses maintain or improve their patient care skills? (HR)

How is the number of nursing staff decided for each unit? (HR)

What type of patient record documentation is done by nurses? (NR, IM)

If there are nursing students, what are the responsibilities for the hospital and for the educational institution? (NR)

How does the hospital improve nursing care in the entire hospital? (NR)

How do nurses communicate patient information between shifts? (NR)

When do nurses do patient assessments and re-assessments? (PE)

Who can administer medications? (COP)

### Example Observations.

Is there a Nursing Director or Chief Nurse for the hospital? (NR)

Are there job descriptions and required qualifications written for nursing staff? (NR)

### **Personnel Review (Human Resources Review)**

During the personnel review, the surveyors assess relevant standards related to staffing and to the competence of physicians and hospital staff.

#### **Purpose:**

- To review hospital's approach to determining staff qualifications.
- To assess staff orientation, training, and education programs.
- To assess the process used to determine adequate staff to meet the needs of the patients.
- To assess the process used to determine physician qualifications and ongoing competence.

#### **Who Will Participate?**

From the organization:

- Director (or designee);
- Chief Nurse; persons responsible for hiring staff; and
- others at the discretion of the Director.

All surveyors.

#### **What Documents Need to Be Available?**

Policies relating to hiring, staffing, training.

Staffing records.

Personnel files selected by surveyors. (Files may be of physicians, nurses, staff responsible for building maintenance, or other hospital staff).

#### **Example Questions.**

How are qualified staff selected? (HR)

After staff are hired, how do they learn about the hospital and their job responsibilities? (HR)

How do you maintain and improve competence of all staff? (HR)

What is the process if a staff member is unable or unwilling to perform assigned duties? (HR)

Are there any ways for staff to express dissatisfaction to the hospital Director? (LD)

What information is kept in a personnel record? (HR)

How frequently is staff evaluated or given feedback about their performance? (HR)

### Quality Standards Review

During the quality standards review, the surveyors assess relevant standards related to quality improvement and to quality control.

#### Purpose:

- To assess standards related to quality improvement.

#### Who Will Participate?

From the organization:

- Director (or designee);
- person(s) responsible for collecting and analyzing data related to quality control or quality improvement;
- person(s) responsible for collecting and analyzing data related to hospital acquired infections;
- and others at the discretion of the Director.

Nurse Surveyor.

#### What Documents Need To Be Available?

Documentation related to quality control or quality improvement.

Documentation related to hospital acquired infections.

Practice protocols, guidelines, or care maps.

Written quality improvement plan or program.

#### Example Questions.

How do you determine patient satisfaction or dissatisfaction? (RI)

How have you improved the quality of care in the past year? (PI)

How do you know that patient care is of adequate quality? (PI)

What data is currently being collected for quality improvement? (PI)

### **Daily Briefing**

During the daily briefing, the surveyors give the hospital leaders feedback about the findings and address any questions from hospital staff.

#### **Purpose:**

- To provide staff with general observations from the previous day's activities.
- To note issues that the surveyors will continue to address as the survey progresses.
- To give staff a chance to note information surveyors may have missed during the previous day that may affect their understanding of the findings.
- To review the agenda for the upcoming day.

#### **Who Will Participate?**

From the organization:

- Director;
- Economic Director;
- Person responsible for maintaining building services;
- Chief Nurse (or nursing representative); and
- other persons at the discretion of the Director.

All surveyors.



### **Evaluator's Meeting**

During the evaluators' meeting, the surveyors discuss their findings with each other and start to prepare the report for the hospital.

#### **Purpose:**

- To discuss each other's findings from the day.
- To begin documentation and preparation for the exit conference.

### **Exit Conference**

During the exit conference, surveyors present preliminary findings and address questions and comments from staff.

### **Who Will Participate?**

From the organization:

- Director;
- Economic Director;
- Person responsible for maintaining building services;
- Chief Nurse (or nursing representative); and
- other persons at the discretion of the Director.

All Surveyors.

**Sample Survey Agendas**

**1 day/ 1 surveyor**

0800-0830	Opening Conference
0830-0930	Leadership Interview
0930-1230	Unit Visits (Tour Hospital)
1230-1330	Lunch
1330-1430	Medical Record Review
1430-1530	Quality Standards Review
1530-1600	Personnel/ Nursing Review
1600-1630	Prepare Report
1630-1730	Exit Conference

2/

**2 days/ 2 surveyors**

**Day 1**

0800-0830	Opening Conference (MD and Nurse)	
0830-1000	Leadership Interview (MD and Nurse)	
1000-1100	Operating Room Visit (Nurse)	Emergency Services Visit (MD)
1100-1230	Unit Visit (Nurse)	Unit Visit (MD)
1230-1330	Lunch (MD and Nurse)	
1330-1430	Personnel review (MD and Nurse)	
1430-1530	Quality Standards Review (Nurse)	Medical Record Review (MD)
1530-1600	Evaluators Meeting (MD and Nurse)	

**Day 2**

0800-0830	Daily Briefing	
0830-0930	Unit Visit (Nurse)	Unit Visit (MD)
0930-1030	Unit Visit (Nurse)	Unit Visit (MD)
1030-1130	Unit Visit (Nurse)	Unit Visit (MD)*
1130-1230	Nursing Interview (Nurse)	Pharmacy Visit (MD)
1230-1330	Lunch (MD and Nurse)	
1330-1430	Sterile Processing or Kitchen Visit (Nurse)	Laboratory Services Visit (MD)
1430-1530	Evaluators Meeting	
1530-1630	Exit Conference	

\*As needed, visit Radiology services.

**Standards Abbreviations**

CC	Continuity of Care
COP	Care of Patient
EC	Environment of Care
HR	Human Resources (Personnel Standards)
IC	Infection Control
IM	Information Management
LD	Leadership
NR	Nursing
PE	Physical Assessment
PI	Performance Improvement (Quality Standards)
RI	Patient Rights



## **Data Sources**

The following data sources are used during the survey process.

- Documentation review. Many documents are reviewed, including: safety plans; quality improvement and quality control information; and equipment maintenance records
- Interviews. The surveyor interviews patients, physicians, and staff. The interviews may be of an informal nature (ex. casual conversation) or more formalized (ex. The leadership interview). Interview questions should be open-ended (i.e. not able to be answered with a “yes” or “no” response) in order to encourage participation.
- Medical records. Both open (patient is still in the hospital) and closed (patient has been discharged or transferred) records are reviewed .
- Observations. During a survey, many observations are made. For example, observations are made relating to the environment (is it safe?). Observations are made relating to care delivered by both physicians and nursing staff. Observations are made relating to activities performed by staff that would minimize the spread of infections

**APPENDIX C**

**Romania Accreditation Scoring Sheet**

**I. Source of Information to Score**

DR	Document Review
HR	Human Resources Record
PR	Personal or Medical Record of the Patient
WI	Interview with Staff on the Ward
OW	Observation on the Ward
LI	Interview with Leaders

**II. Scoring Scales**

A. Logical	Yes - No	5 - 1
B. Qual	Always	5
	Mostly	4
	Sometimes	3
	Seldom	2
	Never	1
C. Quant	90-100%	5
	80-89%	4
	70-79%	3
	60-69%	2
	less 59%	1

STANDARD	DESCRIPTION	SOURCE	SCALE	EVAL SC	OBSERVATIONS/COMMENTS
5.1	There is a written statement of the scope of care for emergency services approved by the board of directors and the chief of emergency services	DR	A		
5.1.1	The statement is periodically reviewed and updated	DR	A		
5.1.2	The statement indicates the date of review	DR	A		
5.1.3	The statement includes definitions of:				
5.1.3.1	Emergency medical conditions	DR	A		
5.1.3.2	Situations requiring transfer to a facility with specific specialty services not available at the hospital	DR, PR	C		
5.1.3.2.1	No patients are transferred if the required care can be provided at the hospital	DR, PR	C		
5.1.3.2.2	No patient can be transferred without prior acceptance by the receiving hospital and the acceptance is documented in the transfer note and the emergency department ledger	DR, PR	C		
5.1.3.2.3	Every transferred patient is accompanied by qualified personnel	DR, PR	C		
5.1.3.2.4	Every transferred patient has a transfer note which includes	DR, PR	C		
5.1.3.2.4.1	The identity of the patient	DR, PR	C		
5.1.3.2.4.2	The diagnosis	DR, PR	C		
5.1.3.2.4.3	Treatment and care prior to transfer	DR, PR	C		
5.1.3.2.4.4	The transfer note is signed by the physician in charge	DR, PR	C		
5.1.3.2.4.5	The transfer note includes the official hospital stamp	DR, PR	C		
5.1.3.2.4.6	The transfer note states the destination hospital	DR, PR	C		
5.2.1	The emergency service is a separate department with an organizational plan which includes definitions of:	DR, LI	A		
5.2.1.1	Function	DR	A		
5.2.1.2	Structure and organization (facilities and staffing)	DR	A		

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5.2.1.3	Relationships with other hospital department and	DR	A
5.2.1.4	Relationships with other hospitals and agencies	DR	A
5.2.2	The emergency service will be directed by a physician qualified in emergency care (training and experience)	DR, HR, LI	A
5.2.3	The emergency service is operating 24 hours per day	DR, LI	A
5.2.4	There is a staffing plan for adequate numbers of physicians, nurses and others based on projected patient volumes and acuity levels	DR, LI, WO	B
5.2.4.1	There is a plan for utilization of staff from other hospital departments and from outside of the hospital when necessary	DR, LI	A
5.2.5	Nursing personnel have appropriate training and experience in emergency nursing	LI, HR	B
5.2.5.1	A trained emergency staff nurse is always present within the emergency service	DR, LI, WO, HR	A
5.2.6	Physician are immediately available to the emergency service	LI, WO	B
5.2.6.1	Physicians with training and experience in emergency medicine are always present within the emergency service in emergency hospitals	DR, LI, WO, HR	A
5.2.7	All emergency services personnel have emergency response training according to their professional training level.	LI, WO, HR	B
5.2.7.1	The hospital has implemented a plan to provide periodic emergency response training for its emergency services staff	DR, LI, HR	A
5.2.8.1	Services provided are timely	WI, WO, PR	B
5.2.8.2	Services provided are complete	WI, WO, PR	B
5.2.8.3	Services are provided with respect and caring	WI, WO, PR	B
5.2.9.1	Services respect the privacy of the patient	WI, WO, PR	B
5.2.9.2	Services respect the dignity of the patient	WI, WO, PR	B

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5.2.9.3	Services respect the cultural and religious beliefs of the patient	WI, WO, PR	B
5.2.10	Patients or their legal representatives are informed about the choices of treatment, prognosis of the disease and possible complications	WI, PR	B
5.2.11.1	The identity of hospital personnel is visible	WO	B
5.2.11.2	Wherever services are delivered, names of the persons in charge are visible	WO	B
5.3.1.1	There is free access to E.S. either from inside or from outside the hospital	WO	A
5.3.1.2	Ambulances must always have clear, unobstructed access to Emergency Services	WO	A
5.3.1.3	There is adequate signage to Emergency Services from within and from outside the hospital	WO	B
5.3.2	There is adequate space for the provision of emergency care	WI, WO	B
5.3.2.1	There is a separate room for traumas	WO	A
5.3.2.2	There is a separate room for minor surgery	WO	
5.3.2.3	There is a separate room for fractures	WO	
5.3.4.1	Equipment used in Emergency Services is in working order	WO, WI	B
5.3.4.2.1	Suction equipment must be ready to use	WO, WI	B
5.3.4.2.2	Oxygen must be always available	WO, WI	B
5.3.5.1.1	There is always available necessary drugs as required by the MOH	WO, WI	B
5.3.5.1.2	There is always available necessary i.v. fluids as required by the MOH	WO, WI	B

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5.3.5.1.3	There is always available necessary materials as required by the MOH	WO, WI	B
5.3.5.2	Emergency Services must always be able to provide necessary drugs, equipment, and trained personnel to provide emergency care for the full range of medical and surgical emergencies including	WO, WI	B
5.3.5.2.1	bleeding	WO, WI	B
5.3.5.2.2	airway obstruction	WO, WI	B
5.3.5.2.3	cardiac arrhythmia	WO, WI	B
5.3.5.2.4	traumatic injury	WO, WI	B
5.3.5.2.5	burns	WO, WI	B
5.3.5.2.6	bites (including insects and snakes)	WO, WI	B
5.3.5.2.7	poisonings and intoxications	WO, WI	B
	emergency childbirth	WO, WI	B
5.3.6.1	There must be equipment necessary for defibrillation	WO, WI	B
5.3.6.2	There must be equipment necessary for tracheal intubation in sizes suitable for all ages	WO, WI	B
5.3.6.3	There must be equipment necessary for tracheotomy in sizes suitable for all ages	WO, WI	B
5.3.6.4	There must be equipment necessary for mechanical ventilation in sizes suitable for all ages	WO, WI	B
5.3.6.5	There must be equipment necessary for pleural decompression in sizes suitable for all ages	WO, WI	B
5.3.6.6	There must be equipment necessary for venous access in sizes suitable for all ages	WO, WI	B
5.3.7.1	Laboratory services are available around the clock	WO, WI	A



5.3.7.2	Radiology or other imaging services are available around the clock	WO, WI	A
5.3.8	There are adequate numbers of personnel on duty to accompany patients safely to these offsite services	WO, WI	B
5.3.8.1	There are adequate means of transportation available for patients to be transported safely to these services	WO, WI	B
5.3.9	Emergency Services prepare in advance when notified of the expected arrival of serious cases	DR, WO, WI	A
5.3.10.1	There is a functional communication system between E.S. and other community services especially ambulances, police, and fire department	WO, WI	B
5.3.10.2	There is a functional communication system between E.S. and other departments of the hospital around the clock	WO, WI	A
5.3.10.3	Communication systems will have backup circuits available in case of the failure of main circuits	WO, WI	A
5.3.10.4	All the personnel working in E.S must attend periodic training regarding the operation of communication equipment	WI, HR	B
5.4.1	There are written procedures in accordance with the regulation which include at a minimum the following topics:		
5.4.1.1	Location of storage for drugs, materials and equipment	DR, WO	A
5.4.1.2	Comprehensive lists with names, addresses, phones of personnel potentially available	DR, WI, WO	A
5.4.1.3	Instructions regarding confidentiality	DR, WI	A
5.4.1.4	A communication plan with interested agencies regarding contagious diseases, victims of accidents, crimes	DR, WI	A
5.4.1.5	Instructions regarding specific care for the following:	DR, WI	A
5.4.1.5.1	emotionally unstable patients	DR, WI	A
5.4.1.5.2	patients under the influence of drugs and alcohol	DR, WI	A

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5.4.1.5.3	victims of criminal acts	DR, WI	A
5.4.1.5.4	patients contaminated with radioactive material	DR, WI	A
5.4.1.5.5	patients arrived dead at the hospital	DR, WI	A
5.4.2	The role of Emergency Services is specified in case of natural hazards or disasters	DR, LI, WI	A
5.4.3	Instructions and written procedures regarding health professionals working in E.S. must include the following:		
5.4.3.1	Personnel responsibilities (job descriptions)	DR, HR, WI	A
5.4.3.2	Prohibited procedures within E.S.	DR, WI, WO	A
5.4.3.3	Circumstances when further care is not provided	DR, WI	A
5.4.3.4	Procedures for referral to consultants	DR, WI	A
5.4.3.5	The use of observation beds and maximum permissible length of stay in E.S.	DR, WI, WO	B
5.4.3.6	Permitted circumstances for delayed admission	DR, WI, WO	B
5.4.3.7	Circumstances when patients are to be admitted directly	DR, WI, WO, PR	B
5.4.3.8	Written recommendations at discharge from E.S. for patients and /or their relatives		
5.4.4	Written materials regarding toxic substances or antidotes must be available within E.S.	DR, WO, WI	A
	Within Emergency Services there must be charts regarding:		
5.4.5.1	Initial treatment of burns	WO	A
5.4.5.2	Cardiorespiratory resuscitation	WO	A
5.4.5.3	Immunization against tetanus	WO	A
	Every Emergency Services medical record must include:		
5.5.1.1	the identity of the patient	PR	C
5.5.1.2	time of arrival	PR	C
5.5.1.3	means of transportation	PR	C



5.5.1.4	persons who accompanied the patient	PR	C
5.5.1.5	the accident or the disease of the patient	PR	C
5.5.1.6	prior treatment	PR	C
5.5.1.7	signs and symptoms	PR	C
5.5.1.8	the results of the tests	PR	C
5.5.1.9	diagnostic	PR	C
5.5.1.10	treatment	PR	C
5.5.1.11	status of patient when leaving the E.S.	PR	C
5.5.1.12	instructions given to patient and / or relatives	PR	C
5.5.2	The doctor in charge is responsible for the correctness of this record which is signed by him/her	PR	C
5.5.3	The emergency record is part of the personal medical record of the patient, if admitted	PR	C
	The Emergency Services ledger includes the following:		
5.5.4.1	a single code number for each visit	DR	C
5.5.4.2	name of the patient	DR	C
5.5.4.3	date and time of arrival	DR	C
5.5.5	E.S. records are periodically reviewed for appropriateness and quality of care provided in Emergency Services	DR, LI, WI	B



<b>Romania Accreditation Scoring Sheet</b>		<b>SOURCE</b>	<b>SCALE</b>	<b>EVAL SC</b>	<b>OBSERVATIONS/COMMENTS</b>
<b>Standard</b>	<b>Description</b>				
2.1	The hospital environment assures protection for patients, personnel and visitors and there are provisions in the event of natural disasters				
2.1.1	There is a fire escape plan	DR, LI	A		
2.1.1.1	The plan is visible on each floor	WO	B		
2.1.2	Fire extinguishers and hoses exist according to law	WO	A		
2.1.2.1	There is an escape route	WO	A		
2.1.2.2	The escape route is isolated from the fire	WO	A		
2.1.3	The location of emergency fire exit doors is clearly indicated	WO	B		
2.1.3.1	Access to the escape doors is clear and obstructed	WO	B		
2.1.4	All elevators are maintained in working order	WO	A		
2.1.5	There is permanent, unobstructed access to elevators and stairs	WO	B		
2.1.6	Hospital personnel have current training in fire prevention and control	LI, WO, HR	C		
2.1.6.1	Each patient room clearly indicates a fire escape route	WO	B		
2.1.7	There is an emergency preparedness plan in regard to disasters such as earthquake	DR, LI	A		
2.1.7.1	Hospital personnel receive training at the time of hire and yearly thereafter	DR, WI	C		
2.1.7.1.1	Training records will be maintained in the personnel files	HR	C		
2.2	There is a written plan for prevention of damage or injury from external disaster	DR, LI	A		
2.2.1	The plan is approved by the governing body	DR	A		

2.2.1.1	The plan is reviewed and/or updated yearly	DR	A
2.2.2	Emergency hospitals have specific disaster plans to address disasters occurring in the community such as plane crash, train wreck, industrial accident, etc.	DR, LI	A
2.2.2.1	Such plans include management of the following situations:		
2.2.2.1.1	Loss of water	DR, LI	A
2.2.2.1.2	Loss of electricity	DR, LI	A
2.2.2.1.3	Deaths exceeding morgue capacity	DR, LI	A
2.2.2.1.4	Seriously injured patients exceeding operating room capacity	DR, LI	A
2.2.2.1.5	Seriously injured patients exceeding hospital blood bank capacity	DR, LI	A
2.2.2.1.6	Seriously injured patients exceeding personnel capacity, including physicians and nurses	DR, LI	A
2.3	Non-medical personnel are qualified by training and experience	WI, HR	B
2.4	Personnel are trained in the safe use of equipment	WI, HR	B
2.4.1	There is a written program for training in equipment use	DR, HR	A
2.5	Patient food service personnel are qualified by training and experience	HR	B
2.5.1	Each patient receives food appropriate to his particular needs	WO, WI, PR	B
2.5.2	Food preparation is consistent with regulation	WO, DR	B
2.5.2.1	Gloves and hair covering are worn as required	WO	B
2.5.3	Food is served to patients consistent with regulation	WO, WI	B
2.5.3.1	Food is served at appropriate temperature	WO, WI	B
2.5.3.3	Food is available at alternative times when required by medical necessity	WO, WI	B

2.5.3.4	Provision is made for safe storage of food brought by patients or family	WO, WI	B
2.5.3.4.1	Food and beverages brought by patient/family are consistent with the physician's orders for nutritional needs	PR, WO, WI	B
2.5.4	Health of food service personnel is evaluated consistent with regulation	HR	B
2.6	Temperature of patient rooms and patient care areas is maintained within an acceptable range (18-22C)	WO, WI	B
2.7	Hospital premises including patient care areas have adequate lighting	WO, WI	B
2.8	Patient care areas have adequate ventilation	WO, WI	B
2.9	There is a separate designated room/area for patients to meet with family/visitors	WO	A
2.9.1	In hospitals with children, there are designated areas for play	WO	A
2.9.2	In hospitals with children, there are designated areas for educational activities	WO	A
2.10	The hospital has implemented an effective plan for the control of animal and insect vectors of disease (mosquitoes, dogs, roaches, etc.)	WO, WI, LI	B
2.11	The hospital effectively eliminates hazards to patients and staff inside and outside of the building including slippery surfaces, standing water, broken pavement, etc.	WO, WI LI	B
3.1	<b>Nursing Director</b>		
3.1.1	There is a single Nursing Director for the hospital who	DR, LI	A
3.1.1.1	Is a graduate of a secondary school	HR	A

3.1.1.2	Has completed a management course or equivalent	HR	A
3.1.1.3	Works effectively (organize, co-ordinate, evaluate nursing activity)	DR, LI, WI, WO	B
3.1.2	There is a chief nurse in each department responsible to the nursing director for quality and continuity of service who:	DR, LI, HR	C
3.1.2.1	Possesses appropriate education	HR	C
3.1.2.2	Possesses appropriate experience	HR	C
3.1.3	The Nursing Director collaborates with the medical director to:		
3.1.3.1	Organize nursing services	LI, DR, WO	B
3.1.3.2	Assign personnel and positions/duties as appropriate	LI, DR, WO	B
3.1.3.3	Propose nurse training and improvement	LI, DR, WO	B
3.1.4	Nursing Director's recommendations are considered in decisions regarding nursing	LI, DR	B
3.1.5	Nursing staffing on each ward or department considers		
3.1.5.1	The number and type of patients	DR, LI, WO	B
3.1.5.2	Matters regarding infection control	DR, LI, WO	B

**The Hospital Plan for Nursing**

3.2	The nursing activity is carried out according to a written organizational plan in which the structure and function of nursing personnel are defined; the plan also contains methods for the evaluation of their activity.		
3.2.1	A written organization plan for nursing is present	DR	A
3.2.1.1	The plan is integrated into hospital plans	DR	A
3.2.1.2	The plan is accessible to all nurses	WI, LI	B



3.2.1.3	The plan is revised periodically	DR, LI	A
3.2.2	The plan includes an organizational chart of nursing personnel	DR	A
3.2.2.1	Functions and responsibilities of each position are contained within job descriptions	DR	A
3.2.2.2	Job descriptions are up to date and signed	DR, WI	A
3.2.3	Plan includes structure and responsibilities for nursing student education when such education is present at the hospital	DR, LI	A

#### Nursing Care

3.3	For each patient there is a written plan that focuses upon safe and effective care		
3.3.1	Each patient has a written nursing plan of care	PR, WI	C
3.3.1.1	The plan is correlated with medical plans	PR, WI	C
3.3.1.2	The plan is available to staff caring for the patient	PR, WI	C
3.3.2	The plan includes		
3.3.2.1	Recommendations of doctors and nurses	PR	C
3.3.2.2	Nursing care needs of the patient	PR	C
3.3.2.3	Short and long term nursing care objectives and interventions	PR	C
3.3.2.4	Information regarding the patient and family	PR	C
3.3.2.5	Evaluation of the nursing care	PR	C
3.3.3	The plan is created at admission and	PR	C
3.3.3.1	Revised as necessary	PR	C
3.3.4	An activity report from each shift is present on each patient (If a plan is available only significant events will be reported)	PR	C
3.3.5	There are monthly meetings of nursing personnel to review care and recommend improvement	DR	B
3.3.5.1	Participants and subjects reviewed are documented	DR	B



**Nursing Education**

3.4	Nursing personnel participate in programs for continuous training and education		
3.4.1	A training and education program for nursing personnel is present	LI, WI	A
3.4.1.1	The program includes orientation of new nursing personnel to their jobs	LI, WI	A
3.4.2.1	The program is conducted by qualified persons	DR, LI	B
3.4.3.1	Each educational session is evaluated by the participants	DR, LI	B
3.4.4.1	The program includes education updates regarding equipment, standards, technology and new care methods as appropriate	DR	A
3.4.5.1	The nursing director maintains the records and documentation of the program	DR, LI	A
3.4.6.1	The hospital provides professional journals and books to support nursing education and care	LI, WI	A

**Information Management**

4.1	All patients have a personal file/register which is used to:	PR	A
4.1.1	Plan medical and nursing care	PR	C
4.1.2	Provide for continuity of care	PR	C
4.1.3	Evaluate the results of care	PR	C
4.1.4	Describe the status and progress of the patient during care	PR	C
4.1.5	Protect the legal interests of the patient, staff and hospital	PR	C
4.1.6	Provide data for quality improvement	PR	C
4.1.7	Evaluate the use of drugs and materials	PR	C

4.2	The minimum requirements for the medical record regardless of format are:		
4.2.1	Identification data (If this is not possible, the motive has to be stated	PR	C
4.2.1.1	Name and surname (complete), birth data, address	PR	C
4.2.1.2	Contact person	PR	C
4.2.1.3	Patient's identification number (unique to the hospital) and medical file identification number	PR	C
4.2.2	History of the disease/complaint	PR	C
4.2.2.1	Physiological and pathological personal history	PR	C
4.2.2.2	Behavioral data and socio-economic information	PR	C
4.2.2.3	Reason for requiring hospitalization	PR	C
4.2.2.4	Relevant data provided by pre-clinical services and/or transferring hospital	PR	C
4.2.3	Results of the physical examination	PR	C
4.2.3.1	Completed as quickly as possible and not more than 24 hours after admission	PR	C
4.2.3.2	Contains detailed data regarding body systems (respiratory, cardiovascular, digestive, excretory, musculo-skeletal, endocrine, sensory organs, nervous system, etc.	PR	C
4.2.3.3	The admission physical examination must be signed by the physician who assessed the patient	PR	C
4.2.3.4	The physical examination must lead to a primary diagnosis and is the basis for a laboratory investigation and therapy plan	PR	C
4.2.4	Written and signed informed consent is obtained	PR	C
4.2.4.1	The risk associated with procedure or treatment is stated in writing	PR	C

4.2.4.2	A signature of the patient or family member acknowledges receipt of such information	PR	C
4.2.5	Diagnosis and therapeutic recommendations and their outcomes are recorded	PR	C
4.2.5.1	The doctor in charge records in the medical file any diagnosis or treatment recommendation	PR	C
4.2.5.2	Date (and hour, for emergencies) of recommendations for each investigation (or set) is recorded	PR	C
4.2.5.3	Verbal orders regarding potentially dangerous procedures or medications are authenticated by the signature of the doctor in charge within 24 hours	PR	C
4.2.5.4	Results from the laboratory, pathology and radiology are recorded in the medical file within 24 hours after the test is performed	PR, WI	B
4.2.5.5	A diagnosis is recorded before any surgical intervention	PR	C
4.2.5.6	The written anesthesia protocol documents the type of anesthesia to be used and its associated risks	PR	C
4.2.5.7	The surgical protocol is written immediately after surgery and contains:	PR	C
4.2.5.7.1	Physical examination and surgical diagnosis	PR	C
4.2.5.7.2	Surgical procedure	PR	C
4.2.6	Data describing the patient's progress	PR	C
4.2.6.1	Progress notes are written at least every 24 hours	PR	C
4.2.6.2	Subjective conclusions of change in status are supported by objective data (I.E., heart rate, blood pressure, temperature, etc.)	PR	C
		PR	C
4.2.7	Final conclusions (epicrisis) and recommendations include:	PR	C

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4.2.7.1	Reasons for admission	PR	C
4.2.7.2	Pertinent clinical and laboratory information	PR	C
4.2.7.3	Treatment provided	PR	C
4.2.7.4	Patient status at discharge	PR	C
4.2.7.4.1	Supported with objective data	PR	C
4.2.7.4.2	Compared with admission status	PR	C
4.2.7.5	Recommendations for the patient and family including	PR	C
4.2.7.5.1	Physical activity	PR	C
4.2.7.5.2	Diet	PR	C
4.2.7.5.3	Home care and treatment	PR	C
4.2.7.5.4	Follow-up	PR	C
4.2.7.6	A copy of this information will be provided to the patient/family	PR	C
4.2.7.7	In case of death, necropsy results (if any) and cause of death will be mentioned and a death certificate will replace the discharge note.	PR	C

4.3	<b>Medical Records</b>		
4.3.1	Patient medical records are owned by the hospital	DR, LI	A
4.3.2	The hospital must protect records and their content from loss, destruction, theft and use by unauthorized persons	DR, LI	A
4.3.3	Access to medical record information is limited to medical personnel providing direct care, the admitting physician and those with a legal right	DR, LI	A
4.3.3.1	Access by others is allowed only following written consent by the patient/family. except under specific circumstances*	DR, LI	A

4.4	<b>Medical Records Department</b>		
4.4.1	There is a qualified department coordinator responsible to the hospital director	HR, LI	A
4.4.2	The coordinator provides for continuous education of the medical statistics personnel	HR, LI	B
4.4.3	The department is adequately equipped to provide easy, secure access by authorized persons	DR, WO, LI	B
4.4.4	All medical records and nursing plans are archived together in the patient's personal file using a unique identified (personal code).	DR, WO	A
4.4.5	Diagnoses are coded according to the most recent ICD	DR	A
6.0	<b>Infection Control</b>		
6.1	There is a hospital wide infection control program which includes	DR	A
6.1.1	Definitions	DR	A
6.1.2	A reporting system	DR	A
6.1.3	Ongoing review and evaluation	DR	A
6.1.4	Written procedures on isolation	DR	A
6.1.5	Procedures for infection control in non-clinical areas	DR	A
6.1.6	Laboratory support for the program	DR	A
6.1.7	Procedures for integration with employee health	DR	A
6.1.8	New employee orientation for the infection control program	DR	A
6.1.9	Coordination with the medical staff on review and actions related to antibiotic use	DR	A
6.2	There is a multidisciplinary infection control committee	DR, LI	A

6.2.1	The committee monitors the infection control program	DR, LI	A
6.2.2	Membership on the committee includes medicine, nursing, administration and others identified in the policy	DR, LI	A
6.2.3	The chief of the committee is a physician with infection control experience	HR, LI	A
6.2.4	Responsibilities of the committee include:	DR, LI	A
6.2.4.1	Determine the type of surveillance and reporting	DR, LI	A
6.2.4.2	Determine the criteria for reporting	DR, LI	A
6.2.5	Infection control information is collected by nursing on each ward	DR, PR, LI, WI	C
6.2.6	The committee meets at least every two months	DR, LI	A
6.2.7	The committee evaluates the effectiveness of the program by considering	DR, PR, LI	A
6.2.7.1	Infections in the hospital	DR, PR, LI	A
6.2.7.2	Required bacteriological cultures of personnel and the hospital environment	DR, PR, LI	A
6.2.7.3	Results of susceptibility/resistance studies	DR, PR, LI	A
6.2.7.4	Protocols for special studies	DR, PR, LI	A
6.2.7.5	Reporting/recording of infections in the medical files of patients	DR, PR, LI	A
6.2.7.6	Findings from other committees	DR, PR, LI	A
6.2.8	The findings of the committee are reported to medical staff, hospital director, nursing director, chief nurses	DR, LI	B
6.3	There are written infection control procedures which are:	DR	A
6.3.1	Used in all hospital wards	DR, WO	A
6.3.2	Reviewed and revised yearly by the infection control committee	DR	A

6.3.3	Developed with the cooperation of the departments and wards as appropriate	DR, WI, LI	C
6.3.4	Available for all personnel for those activities associated with nosocomial infection	DR, WI, LI	B
6.3.5	Available for the use of disposable items	DR	A
6.3.5.1	Disposable items are not reused	WO, WI, LI	B
6.4	<b>Central Services</b>		
6.4.1	There is a department director responsible for central services, sterilization, disinfection and asepsis	DR, HR	A
6.4.2	The department director is responsible to the hospital director	HR, DR	A
6.4.3	The department director is qualified by education and experience	HR	A
6.4.4	There is an educational program for all personnel in central services	HR, DR	A
6.4.5	Written procedures include:		
6.4.5.1	Processing of reusable items	DR	A
6.4.5.2	Processing of sterile equipment and medical supplies	DR	A
6.4.5.3	Use of sterilization monitors	DR	A
6.4.5.4	Shelf life and expiration dates	DR	A
6.4.5.5	How to obtain supplies after hours or when central services is closed	DR	A
6.4.5.6	Preventive maintenance of equipment	DR	A
6.4.5.7	Handling of outdated sterile supplies	DR	A
6.4.5.8	Emergency collection and disposal of recalled supplies	DR	A
6.4.5.9	Elimination of toxic residues from gas-sterilized items	DR	A
6.4.5.10	Cleaning and sanitation in the central services	DR	A

6.4.6	There is sufficient space for efficient operation of central services	LI	A
6.4.7	There is sufficient equipment for efficient operation of central services	LI	A
6.4.8	All sterilizers are regularly tested and the results documented	DR	B
6.5	<b>Housekeeping</b>		
6.5.1	There is a department director responsible for housekeeping services	DR, LI	A
6.5.2	This person is responsible to the director of the hospital	DR, LI	A
6.5.3	The director is qualified by education and experience	HR	A
6.5.4	The director is responsible for:		
6.5.4.1	Developing procedures	DR, LI	A
6.5.4.2	Training and supervising personnel	DR, LI	A
6.5.4.3	Scheduling and staff assignments	DR, LI	A
6.5.4.4	Communicating with all wards and services	DR, LI	A
6.5.5	Written procedures include:		
6.5.5.1	Use and care of equipment	DR	A
6.5.5.2	Cleaning of special areas such as the surgical suite, newborn nursery, etc.	DR	A
6.5.5.3	Proper use of all supplies	DR	A
6.5.5.4	Maintenance of cleaning schedules	DR	A
6.5.5.5	Evaluation of cleaning effectiveness	DR	A
6.5.5.6	Communication with the infection control committee	DR	A
6.5.5.7	Personal hygiene of the housekeeping staff	DR	A
6.5.6	Continuing education is provided and documented	DR, LI, WI	B

6.6		<b>The Laundry</b>	
6.6.1	There is a director responsible for the laundry	DR, LI	A
6.6.2	This person is responsible to the hospital director	DR, LI	A
6.6.3	Clean linen is handled and stored to prevent contamination	WO, LI, WI	B
6.6.4	Soiled linen is handled properly	WO, LI, WI	B
6.6.5	Laundry space is planned, equipped and ventilated to prevent contamination	WO, LI, WI	B
6.6.6	Continuing education is provided and documented	WO, LI, WI	B

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## VII. CONDUCEREA SPITALULUI

**Standard 1. Există un Consiliu Director sau persoane cu aceasta funcție, având ca responsabilitate stabilirea unei strategii, managementul organizației, planificarea activității, precum și asigurarea calității îngrijirilor**

### Interpretare

- 1.1 Consiliul Director are ca responsabilitate elaborarea unui plan strategic de desfășurare a activității intraspitalicești, pentru a acoperi nevoile populației deservite.
- 1.2 Planul strategic conține cel puțin următoarele:
  - a) Rolul și scopul spitalului (misiunea organizației)
  - b) Îndatoririle și responsabilitățile Consiliului Director
  - c) Structura și activitatea Consiliului Director:
    - mecanismul de selectare a membrilor Consiliului
    - responsabilitățile și compoziția comisiilor Consiliului Director, dacă acestea există
    - procedura de desfășurare și periodicitatea întâlnirilor pe comisii sau în plen
  - d) Relațiile de responsabilitate dintre Consiliul Director și
    - autorități superioare acestuia (dacă există)
    - directorul executiv
    - directorul medical
    - directorul de nursing
  - e) Normele de funcționare a Consiliului Director
    - adoptarea acestor norme
    - mecanismul evaluării și modificării normelor.
- 1.3 Din Consiliul Director face parte cel puțin un membru ales al personalului medical, cu drept la cuvânt și drept de vot.
- 1.4 Există un mecanism sistematic și eficient de comunicare între membrii Consiliului Director, administrație și personalul medical și de nursing.
- 1.5 Persoanele voluntare și organizațiile externe ce doresc să sprijine activitatea spitalului trebuie să aibă aprobarea Consiliului Director. Acesta stabilește un mecanism de colaborare cu voluntarii individuali / organizațiile externe.
- 1.6 Se va ține un registru la zi, cu minutele ședințelor Consiliului Director.
- 1.7 Consiliul Director se ocupă de planificarea activității spitalului prin:
  - a) aprobarea bugetului anual al spitalului
  - b) elaborarea unui plan de investiții pe termen lung conform reglementărilor în vigoare
  - c) monitorizarea planului de activitate.
- 1.8 Consiliul Director decide modificările de structură în cadrul spitalului (înființare/desființarea unor departamente/secții sau servicii).
- 1.9 Consiliul Director numește Directorul Executiv și instituie un mecanism de monitorizare a performanțelor acestuia.

- 1.10 Există un Comitet Executiv al Personalului Medical ce face recomandări pe care le supune aprobării Consiliului Director. Recomandările se fac în scris și trebuie să primească un răspuns scris după o perioadă rezonabilă de timp.
- Acțiunile inițiate în următoarele domenii necesită recomandări din partea Comitetului Executiv al Personalului Medical:
- a) Structura și Statutul Personalului Medical
  - b) Mecanismul de evaluare a diplomelor, certificatelor și delimitarea privilegiilor profesionale
  - c) Apartenența la personalul medical (numirile, renumirile și încetarea serviciului); mecanismul prin care încetează calitatea de membru al Personalului Medical
  - d) Privilegiile clinice pentru fiecare medic în parte (definirea, acordarea și revizuirea acestora)
  - e) Procesul de asigurare a calității serviciilor furnizate de personalul medical
  - f) Educație medicală continuă.
- 1.11 Serviciile furnizate de personalul medical, cel de îngrijire și cel auxiliar, constituie obiectul unui program global de asigurare a calității în spital. Întregul personal al spitalului este responsabil de implementarea programului de asigurare a calității serviciilor spitalicești și de monitorizarea acestuia, în vederea:
- a) identificării și rezolvării problemelor
  - b) identificării ocaziilor de a-și îmbunătăți activitatea.
- 1.12 Comitetul Executiv al Personalului Medical este responsabil față de Consiliul Director pentru dezvoltarea, adoptarea și evaluarea periodică a Statutului Personalului Medical; acesta concordă cu politica strategică și misiunea spitalului și respectă normele legale în vigoare. Statutul Personalului Medical intră în vigoare cu aprobarea Consiliului Director; neaprobarea lui trebuie motivată în scris.
- 1.13 Consiliul Director își evaluează propria performanță, alcătuiind rapoarte periodice pe care le înaintează ... (pentru evaluare externă !!).
- 1.14 Consiliul Director asigură transparența în ceea ce privește conducerea spitalului și desemnează o persoană ce reprezintă spitalul în relațiile cu presa și cu publicul.
- 1.15 Consiliul Director va dezvolta și implementa o politică de prevenire a conflictelor de interese, ținând seama de legile existente și de misiunea spitalului.

**Standard 2. Fiecare membru al Consiliului Director este informat asupra drepturilor și responsabilităților sale**

- 2.1 Toți membrii noi ai Consiliului Director participă la un program de orientare care include cel puțin următoarele:
- a) structura și rolul Consiliului Director
  - b) drepturile și responsabilitățile fiecărui membru al Consiliului Director
  - c) atribuțiile membrilor Consiliului Director în cadrul programului de asigurare a calității.
- 2.2 Există un program de educație continuă pentru toți membrii Consiliului Director

**Standard 3. Spitalul este condus în mod operativ și eficient de către Directorul Executiv****Interpretare**

- 3.1 Un director executiv numit de Consiliul Director conduce activitatea spitalului de o manieră conformă cu autoritatea conferită de Consiliul Director, fiind răspunzător în fața acestuia pentru calitatea, oportunitatea și eficiența asistenței medicale acordate pacienților. El trebuie să aibă calificarea necesară pentru activitatea managerială și poate delega responsabilitatea unor sarcini șefilor de departamente/secții și ai serviciilor administrative.
- 3.2 Directorul executiv concepe și pune în aplicare planuri specifice de activitate în baza strategiei stabilite de Consiliul Director.
- 3.3 Directorul executiv face toate demersurile necesare pentru ca:
- a) Spitalul sa funcționeze în conformitate cu legile și reglementările în vigoare
  - b) În conformitate cu strategia stabilită de Consiliul Director, activitatea spitalicească să se conformeze recomandărilor făcute de instituții autorizate să inspecteze spitalul (ex: Poliția Sanitară, Comisia Națională de Acreditare și Calitate, Curtea de Conturi etc.). Aceste recomandări, ca și acțiunile luate ca răspuns la acestea, sunt consemnate și vor fi puse la dispoziția evaluatorilor Comisiei Naționale de Acreditare și Calitate.
- 3.4 Directorul executiv este responsabil de organizarea structurală și funcțională a spitalului:
- a) Desemnează un înlocuitor pe perioadele în care nu este prezent.
  - b) Implementează principiile manageriale în întregul spital, inclusiv prin stabilirea unor relații clare de responsabilitate în cadrul departamentelor și serviciilor și între acestea.
  - c) Evaluează necesarul de departamente și servicii și eficiența funcționării acestora în cadrul spitalului; deciziile de înființare și desființare a departamentelor și serviciilor sunt luate de Consiliul Director și semnate de directorul executiv.
  - d) Implementează mecanisme eficiente de comunicare între și în cadrul departamentelor, serviciilor, administrației și Consiliului Director.
  - e) Coordonează activitatea din întregul spital cu nevoile identificate ale pacienților internați.
  - f) Monitorizează îndeplinirea politicii spitalului referitoare la drepturile și responsabilitățile pacienților, pentru asigurarea satisfacției acestora.
  - g) Satisfacerea nevoilor spirituale ale pacienților, utilizând resursele proprii ale spitalului sau ale comunitatii.
- 3.5 Directorul executiv elaborează planuri financiare, fiind responsabil de activitatea economico-financiară și de bilanțul anual:
- a) Elaborează un buget global al spitalului care trebuie aprobat de Consiliul Director
  - b) Planifică procedurile de cumpărare și controlează utilizarea activelor
  - c) Verifică și aprobă conturile de încasări și plăți, metodele de plată și aranjamentele de credit
  - d) Elaborează metode de control intern pentru a optimiza utilizarea resurselor fizice, financiare și umane
  - e) Monitorizează utilitatea și acuratețea datelor financiare și a indicatorilor folosiți

- f) Implementează un sistem complex de management financiar, folosind atât metoda de contabilitate impusă de lege, cât și o metodă de contabilitate anticipativă în vederea planificării optime a bugetului spitalului și ajustării acestuia în caz de nevoie.

3.6 Directorul executiv elaborează și pune în practică strategiile de utilizare a resurselor umane, încadrându-se în prevederile legale:

- a) Stabilește necesarul, procedura și criteriile de angajare a personalului, fără discriminare de sex, rasă, credință, origine etnică, sau simpatii politice
- b) Se asigură de elaborarea unei fișe a postului și de evaluarea periodică pe baza acesteia a performanței angajaților, la nivelul tuturor departamentelor sau serviciilor
- c) Stabilește criteriile și procedura de acordare/retragere a funcțiilor de conducere și de demitere a personalului.

**DR. CAROL DAVILA TEACHING HOSPITAL OF NEPHROLOGY****The building**

The construction was built in 1930 with an other destination.

The hospital was founded in 1947. The current name was approved by the Ministry of Health in 1994.

The most damaged part of the construction by the 1984 earthquake was consolidated in 1987.

The hospital having an old building, there are a lot of problems concerning water and heating tubing.

**Population deserved:** (Nephrology and Dialysis) 2.7 million

**The current functional structure** (approved 26.06.1996)

- I. Department of Nephrology I      65 beds
- II. Department of Nephrology II    56 beds
- III. Intensive Care Unit            17 beds
- IV. Chronic Haemodialysis Center   32 beds (HD units)
- V. Acute Haemodialysis Center      2 beds (HD units)
- VI. Peritoneal Dialysis Unit        3 beds
- VII. Romanian Renal Registry      -
- VIII. Laboratories:
  - Haematology
  - Biochemistry
  - Microbiology
  - Immunology
  - Pathology
  - Nuclear Medicine
  - Radiology
  - Echoscropy
  - Endoscopy
  - Functional explorations
- IX. Operation room (access for dialysis surgery)
  - Sterilization unit
  - Blood transfusion unit
- X. Admission of patients
  - Admission room
  - Wardrobe
- XI. Pharmacy
- XII. Library
- XIII. Consultation rooms (for outpatients)
  - Nephrology; Urology; Psychotherapy center
- XIV. Administration

**The staff**

	MD (engineers, pharmacists, biologists)	Nurses (technical staff)
I. Department of Nephrology I	11	11
II. Department of Nephrology II	8	16
III. Intensive Care Unit	2	7
IV. Dialysis Center	6	79
V. Romanian Renal Registry	1	3
VI. Laboratories:	18	21
VII. Operation room (aces for dialysis surgery)	1.5	3.5
VIII. Pharmacy	2	5
IX. Administration	3.5	13

**Indicators**

	1995	1996
Consultations	10 362	10 961
Patients admitted	4 302	4 260
The occupation of the bed (days)	303.6 <sup>8 3%</sup>	304.0
Mean duration of the admission (days)	9.1	9.8
Patients deceased	52	39
Index of mortality (%)	1.2	0.9
Total number of laboratory investigations	17 980	18 302
Patients treated by dialysis (DPCA included)	201	213
Number of haemodialysis sessions	24 239	26 567

## **Training Program for Hospital Evaluators    Module 1**

**Day 1                    February 5, 1997**

Faculty

09:00-09:30	Participant's Registration	
09:30-09:45	Introduction of Faculty	N. Constantinovici
09:45-10:00	General Comments from Dr. Russu, US AID and Dr. Russu Ministry Counselor	
10:00-10:45	Accreditation, Licensure, and Certification Dimensions of Performance Benefits of Accreditation	H. Gurley
10:45-11:00	Questions	
11:00-11:15	Break	
11:15-12:00	History of the joint accreditation project with JCI, US AID, and Ministry of Health	N. Constantinovici
1200-12:30	Accreditation Process	C. Fink
12:30-13:00	Questions	
13:00-14:00	Lunch	
14:00-15:00	Standards: Definition; types (structure, process, outcome); functional vs. departmental. What does a good standard look like?	C. Fink
15:00-15:15	Questions	
15:15-15:45	Role of the Evaluator: evaluation, education, and consultation	C. Fink
15:45-16:00	Questions	



**Day 2                      February 6, 1997**

09:00-10:15	Evaluation Techniques Review of Draft Central Eastern Europe Guide to Hospital Survey Process Manual Document Review (administrative and medical records) Staff and Patient Interviews Observation and Unit Visits Data Collection	C. Fink
10:15-10:30	Questions	
10:30-10:45	Break	
10:45-11:30	Three Types of Scoring Scales Yes/No; Percentage Compliance; and Frequency (Always to Never)	C. Fink
11:30-12:00	Examples of Application of the Three Scales	C. Fink
12:00-13:00	Opportunities Available to Evaluators (ex. Education Programs)	C. Fink
13:00-14:00	Lunch	
14:00-15:30	Small Group Discussion of Standards Participants to determine how standards could be evaluated during a survey and ask questions about standards.	
15:30-15:45	Break	
15:45-16:30	Small Group Presentations of Conclusions	
16:30-17:00	Discussion	

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**Day 3      February 7, 1997**

09:00-10:00	Reports and Conclusions Scoring Activity Summary of Program Observations Ministry of Health Update	H. Gurley C. Fink L. Novac
10:00-10:15	Questions	
10:15-10:45	Program Evaluations	
10:45-11:30	Questions and Program Closure	

## **Training Program for Evaluators Module 2**

**Day 1            February 10, 1997**

0900-1100	Update on Scoring Standards	H. Gurley
1100-11:15	Break	
11:15-1300	Review of Guide to Hospital Survey Process Manual Review of Mock Survey Schedule Opening Conference Leadership Interview Unit Visits (Emergency Services and Patient Units) Visit to Kitchen Closed Medical Record Review Nursing Interview Daily Briefings and Exit Conference Reporting to Hospitals	C. Fink
1300-1315	Break	
1315-1630	Visits to Laboratory Services and Operating Room Visit to Pharmacy and Radiology	



**Day 2                      February 11, 1997**

- 0900-0915      Visit to Sterilizing Processing
- 0915-1000      Personnel Review
- 1000-1030      Quality Standards Review
- 1030-1045      Break
- 10:45-1200      Review Accreditation Manual
- 1200-1300      Group Activity on Standards
- 1300-1400      Lunch
- 1400-1500      Group Reporting of Findings
- 1530-1600      Conclusions and Evaluations

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## Wednesday 2/11/97 Mock Survey at Carol Davila Teaching Hospital of Nephrology

### Schedule

0900-1000	Meet with Director- Leadership Interview H. Gurley and C. Fink
1000-1100	Dialysis Unit (H. Gurley) Intensive Care Unit (C. Fink)
1100-1200	Unit Visit (H. Gurley) Nursing Interview (C. Fink)
1200-1300	Unit Visit (H. Gurley) Food Preparation Areas and/or Laundry (C. Fink)
1300-1400	Lunch
1400-1500	Medical Records Review (in archives) H. Gurley and C. Fink
1500-1600	Review findings with Director Meet with evaluators re: observations

## Thursday 2/12/97 Mock Survey at Bagdosar Emergency Hospital

### Schedule

0900-1000	Meet with Director- Leadership Interview H. Gurley and C. Fink
1000-1100	Dialysis Unit (H. Gurley) Intensive Care Unit (C. Fink)
1100-1200	Unit Visit (H. Gurley) Nursing Interview (C. Fink)
1200-1300	Unit Visit (H. Gurley) Food Preparation Areas and/or Laundry (C. Fink)
1300-1400	Lunch
1400-1500	Medical Records Review (in archives) H. Gurley and C. Fink
1500-1600	Review findings with Director Meet with evaluators re: observations

**BASIC CONCEPTS****NOTES****Accreditation**

Accreditation is a voluntary program operated by a private organization that is concerned about the quality of care provided by health care organizations

**Licensure**

Licensure is a legal right that is granted by a government agency pursuant to a statute (law) permitting practice of an occupation (such as medicine or nursing) or operation of an institution (such as a hospital)

**Certification**

Certification is a voluntary program under which health care institutions must meet certain standards in order to qualify for reimbursement under certain federal (U.S. government) programs

## **Joint Commission on Accreditation of Healthcare Organizations**

- Founded 1951
- Private, not for profit
- Accredits 5200 hospitals (90% of hospitals or 95% of beds)
- Accredits 6000 other healthcare organizations

### *JCAHO Accredits*

- General, mental health, children's, and rehabilitation hospitals
- Healthcare networks and comprehensive delivery systems for defined populations
- Home care agencies and organizations
- Nursing homes
- Mental health, chemical dependency and mental retardation/developmental disabilities services
- Ambulatory facilities: outpatient surgery, rehabilitation centers, and others
- Clinical and pathology laboratories

*Joint Commission Board of Governors (N=28)*

American Medical Association	7
American Hospital Association	7
Public Members 6	
American College of Surgeons	3
American College of Physicians	3
American Dental Association	1
Nursing Representative 1	

*The JCAHO mission is to improve the quality of healthcare provided to the public*

It does so by:

- Establishing measures (standards) of the performance of healthcare organizations
- Using standards to objectively and vigorously evaluate these healthcare organizations
- Providing interpretation of standards including accreditation decisions to the healthcare organizations and to the public on request
- Providing education and consultation on using the interpreted standards for decision making and for improving the quality of care and services provided

*Historical Note*

- In 1910 Dr. Ernest Codman proposed following every patient long enough to determine if treatment was effective and to use similar successful treatment for subsequent patients
- In 1913 this concept was adopted by the American College of Surgeons resulting in the Minimum Standard for Hospitals (One page).
- In 1917 only 89 of 692 surveyed hospitals met the requirements. These results were never published.
- In 1926 the first Standards Manual was published (18 pages).
- In 1952 the ACS transferred its Hospital Accreditation Programs to the Joint Commission.
- In the 1970's standards were revised to represent "optimal achievable" levels of quality instead of "minimum essential" levels of quality.

## DIMENSIUNILE PERFORMANTEI

### Definițiile Comisiei unite de Accreditare a Spitalelor

#### I. Facand ceea ce trebuie

**Eficacitatea** unei proceduri sau unui tratament in relatie cu starea pacientului

*Gradul in care ingrijirea unui pacient a aratat ca a atins rezultatele dorite sau proiectate*

**Oportunitatea** unui test, a unei proceduri sau a unui serviciu specific, fata de nevoile pacientului

*Gradul in care ingrijirile furnizate sunt relevante fata de nevoile pacientului, dat fiind nivelul actual al cunoasterii*

#### II. Facand bine ceea ce trebuie

**Disponibilitatea** unui test, unei proceduri, unui tratament sau a unui serviciu de care un pacient are nevoie

*Gradul in care ingrijirile potrivite sunt disponibile pentru a face fata nevoilor pacientului*

**Oportunitatea momentului** in care un test, procedura, tratament sau serviciu necesar, este furnizat pacientului

*Gradul in care ingrijirile sunt furnizate pacientului la momentul cel mai util sau cel mai propice*

**Eficacitatea** cu care testele, procedurile, tratamentele si serviciile sunt furnizate

*Gradul in care ingrijirile sunt furnizate in mod corect, dat fiind nivelul actual al cunoasterii, pentru a obtine rezultatele dorite sau scontate pentru pacient*

**Continuitatea** unor servicii furnizate pacientului luand in considerare alte servicii, alti medici sau alti furnizori si din punct de vedere al timpului

*Gradul de coordonare al ingrijirilor din punctul de vedere al furnizorilor de servicii sau al organizatiilor, precum si coordonarea in timp*

**Siguranta** unui pacient (si a altora) caruia sau carora li se furnizeaza servicii

*Gradul in care riscul unei interventii precum si riscul pentru mediul inconjurator, sunt reduse atat pentru pacient cat si pentru furnizorii de servicii*

**Eficienta** cu care serviciile sunt furnizate

*Relatia dintre rezultatele ingrijirilor si resursele folosite pentru furnizarea ingrijirilor*

**Respectul si grija** cu care serviciile sunt furnizate

*Gradul in care un pacient sau cineva desemnat de acesta este implicat in deciziile de ingrijire a acestuia, precum si gradul in care cei ce furnizeaza servicii o fac cu sensibilitate si respect fata de nevoile, asteptarile si individualitatea pacientului*

**DIMENSIONS OF  
QUALITY****NOTES**

- **Appropriateness**: the degree to which the care/intervention provided is relevant to the patient's clinical needs, given the current state of knowledge.
  
- **Availability**: the degree to which the appropriate care/intervention is available to meet the needs of the patient served.
  
- **Continuity**: the degree to which the care/intervention for the patient is coordinated among practitioners, between organizations, and across time.
  
- **Effectiveness**: the degree to which the care/intervention is provided in the correct manner, given the current state of knowledge, in order to achieve the desired/projected outcome(s) for the patient.
  
- **Efficacy**: the degree to which the care/intervention used for the patient has been shown to accomplish the desired/projected outcome(s).

**DIMENSIONS OF  
QUALITY****NOTES**

- **Respect and Caring**: the degree to which a patient, or designee, is involved in his or her own care decisions, and that those providing the services do so with sensitivity and respect for his or her needs and expectations and individual differences.
- **Safety**: the degree to which the risk of an intervention and the risk in the care environment are reduced for the patient and others, including the health care provider.
- **Timeliness**: the degree to which the care/intervention is provided to the patient at the time it is most beneficial or necessary.

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**COSTS OF POOR  
QUALITY****NOTES**

- Cancelled procedures
- Unprepared patients
- Waste of supplies
- Illegible physician orders
- Misplaced records
- Extended length of stay
- Reprocessing
- Delivery of un-planned services
- Computer re-runs
- Inventory errors
- Patient/family complaints
- Physician/staff complaints

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## Benefits of Accreditation

### **Goal**

Improve efficiency and quality of hospital care in Romania

### **Process**

Evaluate hospitals using nationally accepted standards (expectations of performance)

### **Benefits to patients**

- Being accredited is evidence to the community of a hospital's commitment to provide quality care
- Informs patients of the current quality level of the hospital
- Helps patients select hospitals for their care

### **Benefits to Hospital**

- Increases recognition as a quality oriented hospital
- Provides information where or how care can be improved
- Improves staff satisfaction and performance

### **Benefits to Romania**

- Pushes all hospitals to meet minimal quality requirements
- Reduces quality differences between regions and between hospitals
- Over time will improve the health of all citizens of Romania

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# THE NATIONAL HEALTHCARE ACCREDITATION PROGRAM

## NOTES

### Purpose

- Reduce cost, increase efficiency
- Provide information to reimbursement system
- Increase credibility of health care providers
- Increase public confidence in the reformed health care system

### Requirements of a Successful Accreditation Program

- Is culture-specific
- Serves the political agenda
- Has clear objectives
- Supports desire to learn better ways

## **THE NATIONAL HEALTH CARE ACCREDITATION PROGRAM**

## **NOTES**

### **Forces for Change**

- Economic/political changes
- Health care reform
- Financing system

### **Mission and Purpose**

- To Improve Quality of Care
- To Educate and Consult to Health Care Professionals
- To Achieve Minimal Acceptable Level of Performance by All Hospitals
- To Recognize and Learn from the Very Best Hospitals
- To Advance Social Policy or Health Policy Goals of the Government
- To Identify Sub-Standard Hospitals

### Accreditation Process

- A. Survey length, agenda, composition
- B. Surveyors - qualifications, training
- C. Data collection - methodology
- D. Accreditation decisions
- E. Data base development
  
- F. Issues
  - Need for standardized survey protocol
  - Scoring compliance with standards
  - The survey report
  - Surveyor issues
  - Feedback and disclosure mechanism

## Components of a Healthcare Accreditation System

### A. Design

- range and scope of services
- accreditation cycle
- award option

### B. Infrastructure

### C. Measures of performance

- standards
- indicators

### D. Accreditation decisions

### E. Field operations

### F. Performance data base

### G. Funding

### H. Sustainability

### I. Incentives

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