CHECKLIST FOR SECONDARY CARE ASSESSMENTS

	PATIENT RECORDS CHECKLIST	**Patients**					
Criteria No.	**PATIENT RECORDS** (*Random sample of 5 patient records in each area)*	**1** √	**2** √	**3** √	**4** √	**5** √	**Total Ticks**
2.1.8	General patient consent for proposed care and treatment for each patient						
	Written consent for surgical or invasive procedures						
2.3.5	Assessment form completed for patient values and beliefs						
3.2.11	• Discharge or end of service planning evident • Involvement of patient and family in planning evident • Involvement of potential providers of follow-up services (GP, another facility, specialist, palliative care provider) in discharge planning evident						
3.3.5	Full assessment of patient's needs: • medical • psychological • social • physical • environmental • educational • spiritual • cultural.						
3.3.6	Initial assessment records: • vital signs • weight • height • significant findings.						
3.3.8	A full medical examination was conducted and history taken History and exam entered in record within six hours of admission (time recorded for both)						
3.3.9	• Doctor endorsement of assessment findings • Diagnosis • Planned care or treatment • Date and doctor signature						
3.3.11	If possible, review files of three patients waiting for surgery - admission notes are completed prior to any surgical procedure.						
3.3.12	• Progress of condition • Response to treatment • Results of re-assessments are recorded.						
3.6.2	Presence of patient number/marker for all patients						
3.6.3	Entries in the records are • legible • dated • signed • identifiable as to who made the entry.						

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3.6.5	File list of contents at the beginning of each record						
3.6.9	Files in each area include the following contents: - Details of admission, date and time of arrival - Client/Patient assessment and medical examination - Sheet containing history pertinent to the condition being treated including details of present and past history and family history - Diagnosis by a registered health professional for each entry to the hospital - Details of the client/patient care or treatment plan and follow-up plans - Diagnostic test orders and results of these tests - Progress notes written by medical, nursing and allied health staff to record all significant events such as alterations in the client's/patient's condition and responses to treatment and care - Record of any near misses, incidents or adverse events - Medication sheet recording each dose given - Treatment record - Observation charts, e.g. temperature chart, input and output chart, head injury chart, diabetic chart - Specialist consultation reports - Mode of discharge, e.g. left against medical advice or discharge on will - In case of death, details of circumstances leading to the death of patients.						
3.6.10	For surgical patients, the contents of the file also include: - Anaesthetic notes - Operation record - Consent form.						
3.6.11	Copies of letters of referral to other services						
3.6.12	Presence of alert notations for allergies, adverse drug reactions, radioactive hazards and infection risks For allergies, the case sheet and folder are stamped in bold red with the word ALLERGY.						
3.6.13	Review 5 files of patients discharged within last 4 -5 days for completed discharge summary signed by the doctor (full name) who authorized the discharge						
3.6.14	Evidence of coding system in records reviewed						
4.0	**Operating Theatre Records** (Review records kept in Operating Theatre)						
4.2.16	Records of operation show: • Date and duration of operation • Anatomical site/place where surgery is undertaken • The name of the operating surgeon(s), operating assistants including scrub nurse and the name of						

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	the consultant responsible • The ICD 10 coded diagnosis made and the procedure performed • Description of the findings • Details and serial numbers of prosthetics used • Details of the sutures used • Swab and equipment count • Immediate post-operative instructions • The surgeon's and scrub nurse's signatures.						
4.2.17	Anaesthetic records show: • Date and duration of anaesthesia • Name of surgical operation performed • The name of the anaesthetist, anaesthesia assistant and, where relevant, the name of the consultant anaesthetist responsible • Pre-operative assessment by the anaesthetist • Drugs and doses given during anaesthesia and route of administration • Monitoring data • Intravenous fluid therapy • Post-anaesthetic instructions • Any complications or incidents during anaesthesia • Signatures of anaesthetist and anaesthesia assistant.						
5.0	**Casualty Department** (Review records kept in Casualty Department)						
5.2.9	Individual patient attendance records contain: • Name • Address • Age/Date of birth • Next of kin • Occupation/School • Case number • Telephone number • Date and time of arrival • Time of examination • Diagnoses • Treatment • Minor surgery carried out • Specimens taken • Instructions for follow up • Doctor's or nurse's names and signatures • Medication given to/or taken away • Advice given on discharge.						
8.0	**Maternity Records**						
8.2.9	Separate records for babies						
8.2.10	Records kept after discharge include the combined: - Maternity notes (including care plans) - Birth registration(s) - Labour register - Admission register						

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	- Neonatal and perinatal morbidity and mortality - Maternal morbidity and mortality.						

STAFF FILES CHECKLIST

		Staff					
Criteria No.	**STAFF FILES (*Random sample of five files*)**	**1** √	**2** √	**3** v	**4** v	**5** v	**Total Ticks**
1.5.4	Qualifications and experience appropriate to position, in line with requirements in job description						
1.5.6	Current job descriptions present Job descriptions contain responsibilities						
1.5.8	Document showing induction programme completed						
1.5.11	Performance appraisal in last twelve months Appraisal shows training that needs to be done by person						
1.5.18	Record of training/continuing education for staff						
1.5.20	File cover sheet for individual personnel files lists the following contents: • Personal data • Application form with work history • Job description and conditions of employment • Current and previous performance appraisal • Record of orientation • Record of education and other training • Leave, pay and other information						
7.1.6	Resuscitation training attendance in the past year recorded for doctors, nurses, emergency staff, those likely to provide resuscitation services						
7.1.7	All doctors' files show advanced resuscitation training in last three years						
16.5	Health and safety procedures part of induction training						
16.6	Regular health and safety training attended by all staff						

	UTILITY AND FACILITY MANAGEMENT CHECKLIST		
Criteria	**Utility Item**	**Documented** √	**Observed/ Implemented** √
1.5.15	Staff facilities in each department include: • Rest room • Changing facilities • Personal lockable storage area • Washing/shower facilities • Toilets • Refreshment facilities • Refreshments for on-call/on-duty staff at night • Accommodation for on-call staff in the Hospital premises • Staff housing.		
2.3.2	Separate male and female toilets available in all main areas of hospital		
19.2	Corridors, storage areas, passageways and stairways are well lit.		
19.3	Access ways and exits are unobstructed at all times.		
19.4	Observation of direction signs and exit signs		
19.5	The environment in all patient areas is • clean • well lit • ventilated with adjustable controls for lighting and heating • with decor in good repair.		
19.6	Floor surfaces are non-slip and even.		
19.7	Facilities and equipment for the safety and comfort of patients and visitors are available and functioning and include: • Refreshment facilities and canteen • Quiet rooms for consultations • A public telephone • Baby changing/feeding facilities • Wheel chair / stretcher • Defined and understandable signage system • Adequate Chairs • Cooling device, fans • Separate queues for male and females wherever required • Safe drinking water facilities • Sheltered outside areas with planting and greenery.		
19.9	Each nursing area • has a clean storage and preparation space • is separate from soiled materials, domestic equipment and sluice areas.		
19.10	Separate male and female toilets and bathrooms		

	UTILITY AND FACILITY MANAGEMENT CHECKLIST		
Criteria	**Utility Item**	**Documented** √	**Observed/ Implemented** √
	available and adequate for the number of patients in the ward or department (at least one toilet for every twelve patients). The toilets and bathrooms: - Are kept clean - Are lockable by the patient from the inside but unlockable from the outside - Have doors that open outwards - Ensure privacy at all times - Have a non-slip base - Have grab rails positioned on either side of the toilet - Have an alarm-call within easy reach of the bath and toilet.		
19.11	Shower facilities are available, with warm water for winter months.		
19.12	Separate male and female functioning, clean toilets are available for use by visitors/attendants. Check cleaning schedules		
19.13	Some toilets are available to seriously ill or disabled patients that: • Allow a nurse to stand at each side to manoeuvre a client/patient • Admit a wheelchair • Have washbasins and a mirror at a suitable height for both able and disabled patients.		
19.14	Area for personal possessions for patients		
19.16	Potable water and electrical power are available 24 hours a day, seven days a week. Any stored water is kept clean		
19.17	Alternate sources of water and power for heat and lighting in case of breakdown of the systems are identified, functioning and regularly tested. Priority areas such as ICU and Operating Theatres are identified. Review a three month track record of breakdowns and whether back-ups worked Staff interview to identify any problems		
19.18	Electrical, water, ventilation, medical gas, and other key systems are regularly inspected, maintained and improved, if necessary. Check monthly maintenance schedule Repair log book – time taken for repairs, any outstanding items		