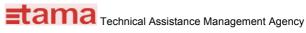
CHECKLIST FOR SECONDARY CARE ASSESSMENTS

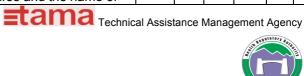
	PATIENT RECORDS CHECKLIST			Pa	tients	;	
Criteria	PATIENT RECORDS (Random sample of 5 patient	1	2	3	4	5	Total
No.	records in each area)	$\sqrt{}$	$\sqrt{}$	$\sqrt{}$	$\sqrt{}$		Ticks
2.1.8	General patient consent for proposed care and						
	treatment for each patient						
	Written consent for surgical 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						
	 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:						
0.0.0	medical						
	psychological						
	social						
	physical						
	environmental						
	educational						
	spiritual						
	cultural.						
3.3.6	Initial assessment records:			1			
3.3.0	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						
0.0.40	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			+		1	
3.6.3	Entries in the records are			+		+	
5.0.0	legible						
	dated						
	• signed						
	identifiable as to who made the entry.						
	ĺ						







0111	PATIENT RECORDS CHECKLIST	Assessment Team No					
Criteria	PATIENT RECORDS (Random sample of 5 patient	1	2	3	4	5	Total
		√	∠ √	3	1 √	3 √	Ticks
No.	records in each area)	V	V	V	V	V	TICKS
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		1	+			
4.0	Operating Theatre Records (Review records kept in Operating Theatre)						
4.2.16	Records of operation show:	 		+			
7.2.10	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						
	assistants including solub hurse and the name of	1	<u> </u>			1	<u> </u>



Date of A	PATIENT RECORDS CHECKLIST	Assessment Team Patients					Number		
Critorio		4	2				Total		
Criteria	PATIENT RECORDS (Random sample of 5 patient	1	2 √	3 √	4 √	5 √	Total		
No.	records in each area)	V	γ	ν	V	γ	Ticks		
	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:								
7.2.17	Date and duration of anaesthesia								
	rame of dargious 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.								
	assistant.								
5.0	Casualty Department (Review records kept in								
5.0									
<u> </u>	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								
	- Autiliooluti tegiolei			1					



Name of Hospital/RHC Date of Assessment

Facility Identifier Assessment Team Number

	PATIENT RECORDS CHECKLIST	Patients					
Criteria	PATIENT RECORDS (Random sample of 5 patient	1	2	3	4	5	Total
No.	records in each area)		$\sqrt{}$	$\sqrt{}$		$\sqrt{}$	Ticks
	 Neonatal and perinatal morbidity and mortality Maternal morbidity and mortality. 						





STAFF FILES CHECKLIST

Criteria No.	STAFF FILES (Random sample of five files)	1 √	2 √	3	4 v	5	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	$\begin{array}{c} \textbf{Documented} \\ \sqrt{} \end{array}$	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	$\begin{array}{c} \textbf{Documented} \\ \checkmark \end{array}$	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		

