Federal Ministry of Health
Health Services Quality Directorate

Hospital Performance Monitoring and Improvement Manual

Second Edition

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MESSAGE OF THE DIRECTORATE

Since its launch in the 1990s, the Health Sector Development Program (HSDP) has led to considerable expansion of the health services through rapid expansion of infrastructure, increased availability of the health workforce; increased budget allocation and improved financial management. However, improvement in Quality of health services at every location is still not perceived, generally.

The Hospital Performance and Monitoring improvement (HPMI) manual was launched in 2011 G.C and revised in 2017 G.C with the aim of providing quality and equitable access to all segment of Ethiopian population. Hospitals are central to these reform efforts and a number of recent initiatives have specifically sought to improve hospital performance and quality of health services. Such initiatives include: Ethiopian Hospital Services Transformation Guidelines (EHSTG), Health Sector transformation in quality (HSTQ), Saving Life through Safe Surgery (SaLTS), Clean and Safe Hospitals (CASH) and the revised Health Management Information System (HMIS) are among others.

HPMI manual has been prepared comprehensively beginning with areas of administrative concerns and disease of high priority. Twenty-Six (26) Key Performance Indicators (KPI) described in this manual are organized into 11 categories under hospital management, outpatient services, emergency services, inpatient services, maternity services, pharmacy services, laboratory service, productivity, human resources, finance and clinical governance.

In addition, the HPMI manual in accompany with the HSTQ and EHSTG guidelines, are going to be the main tools to transform the administrative and clinical process of hospital functions. Using these tools, the ministry of Health has revised the manual and launched it nationwide which is going to be implemented and catalyzed through the EHIAQ platform.

It is, therefore, hoped that all hospitals will take advantage of these guidelines and quick and time bound actions as per the road map placed in HPMI guideline.

I must appreciate the efforts of all experts and partners involved in the preparation and finalization of these manual.

I also deeply appreciate the commitments of all staffs of Health Service Quality Directorate of the ministry for finalizing this manual after a series of consultative meetings and workshops.

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The development of the Manual for the Performance of Monitoring and Improvement (HPMI) in the Health Sector is a culmination of the efforts of all health sector stakeholders that were spearheaded by the Health Service Quality Directorate (HSQD) in the Ministry of Health. A national taskforce was appointed by the director to oversee and coordinate the technical and consultative processes in the development of the manual through the HPMI technical working group. The standards and procedures outlined in this document are aimed at operationalizing the Hospital's Performance Monitoring framework, as well as setting the minimum threshold for establishing enduring Monitoring and improvement functions in health institutions at the national level.

Invaluable efforts and commitments went into this endeavor. I wish to appreciate the constructive input and oversight exercised by members of the health sector's HPMI technical working group (HPMI TWG). Working together with the national taskforce, their incisive contributions, expertise and direct engagement have shaped this document. My sincere gratitude also goes to the 11 Regional health Bureaus, Hospitals and Harvard PGSSC team who participated in, interrogated and validated this document.

FMOH Led Core Team

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ABBREVIATIONS/ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
ALOS	Average Length of Stay
BOR	Bed Occupancy Rate
BPR	Business Process Reengineering
CEO	Chief Executive Officer
CHAI	Clinton Health Access Initiative
CRCPTs	Curative and Rehabilitative Core Process Teams
CG&QMU	Clinical Governance and Quality Management Unit
DOTS	Directly Observed Therapy (Short Course)
EHSTG	Ethiopian Hospital Services Transformation Guidelines
EHMI	Ethiopian Hospital Management Initiative
EPI	Expanded Program on Immunization
FMOH	Federal Ministry of Health
FTE	Full time equivalent
HMIS	Health Management Information System
HCFR	Healthcare Finance Reform
H-CAHPS	Hospital Consumer Assessment of Health Providers and Systems
HR	Human Resources
HSDP	Health Sector Development Plan
HSQD	Health service Quality Directorate
HSTQ	Health sector transformation in Quality
I-PAHC	Inpatient Assessment of Health Care
KPI	Key Performance Indicator

MHA   Masters in Hospital and Healthcare Administration

MCH   Maternal and Child Health

NHS   National Health Service (UK)

NGO   Non-Governmental Organization

OPD   Outpatient Department

O-PAHC   Outpatient Assessment of Health Care

PNC   Post Natal Care

RHB   Regional Health Bureau

SMT   Senior Management Team (Hospitals)

SEHC   Satisfaction of Employees in Health Care

TB   Tuberculosis

VCT   Voluntary Counseling and Testing

Section 1: Introduction

1.1 Background

Federal Ministry of Health through the Health Sector Transformation Plan (HSTP-I) envisions all of its citizens to enjoy quality and equitable access to all types of health services. To realize this, the FMOH and RHBs are leading a sector wide reform to strengthen and improve the quality of health services in Ethiopia. Hospitals are central to these reform efforts and a number of recent initiatives have specifically sought to improve hospital performance and quality of services. Such initiatives include: Ethiopian Hospital Services Transformation Guidelines (EHSTG), Health Sector transformation in quality (HSTQ),Saving Life through Safe Surgery (SaLTS) and Clean and Safe Hospitals (CaSH) and the revised Health Management Information System (HMIS) and Demographic and health information system two (DHIS2) are among others.

Measurement is central to the concept of quality improvement; it provides a means to define what hospitals actually do, and to compare that with the original targets in order to identify opportunities for improvement. This is addressed through the monitoring and evaluation of health sectors which consists of routine data collection, aggregation and dissemination, performance monitoring and quality improvement, integrated supportive supervision, inspection and operational research/evaluation components. The M&E framework of the HSTP is using multiple data sources including routine administrative sources (such as the Health Management Information System), household surveys (such as the Demographic Health Survey, MIS, EPI coverage survey), health-facility surveys(such as the Service Provision Assessment (SPA) and the Service Availability and Readiness Assessment (SARA), disease and behavioral surveillance, civil registration and vital statistics, financial and management information, censuses, and research studies.

Since its publication in 2010, Ethiopian Hospital Reform Implementation Guideline (EHRIG) and Hospital performance monitoring and improvement manual (HPMI) has played a pivotal role in improving the services provided in Hospitals. The manual provides detailed guidance to ensure that hospitals collect and analyze accurate KPIs data and provides guidance on performance improvement methods that will assist hospital management and staff to act upon the findings of the KPIs. The manual also provides guidance for the Federal Ministry of

Health (FMOH) and Regional Health Bureaus (RHBs) to receive, review and analyze KPI information, and to conduct site visits and facilitate review meetings that aim to strengthen hospital performance.

Currently, different structures to lead and coordinate hospital performance monitoring and Quality improvement activities are formed at different levels across the sector. At Federal Ministry of Health the Health Service Quality Directorate (HSQD) is leading the coordination and harmonization of all quality improvement efforts within the sector and is being guided and overseen by the National Health care Quality Steering Committee (NHQSC). On the other hand Quality Unit (QU) at the Regional Health Bureau is being led by CRCPO and supported by a Regional Health Care Quality Steering Committee to oversee hospital performance and quality improvement activities within the region. All Hospitals have established Clinical Governance and Quality Improvement Unit (CG/QIU) that lead by a full time physician assigned to work in the unit with regular responsibility of coordinating and mainstreaming Quality improvement concepts and activities in all departments in the Health facility. The Quality Unit is being assisted by a Quality committee represented by those heads of both clinical and selected supportive departments and experts working in the health facility. To achieve their functions, these stakeholders (Governing Board, SMT, RHB, QU, FMOH and others) require accurate and timely information about hospital performance to ensure that expectations are being met and to take timely action to address any problems identified.

1.2 Rational for Revision of the HPMI Manual

Hospital performance monitoring and improvement can be defined as a process by which hospitals practices strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure their desired results are being achieved.

The existing HPMI (2011) is revised in 2017 due to a number of driving forces have resulted in the need for KPI revision. Some of the driving forces for revision include: the need to have more quality and equity indicators that will provide details required to operationalize the monitoring and evaluation framework of the HSTP. The commitment to improve the access and transform the quality of health services provided at hospitals with magnified efficiency, accountability and ownership at all level. The requirements to integrate the newly introduced health initiatives and alignment with international indicators are some of the factors that drive the manual revision.

1.3 Purpose of the Manual

The purpose of this manual is to standardize the approach in hospital performance monitoring and improvement process and activities across the sector. It aims to provide hospital senior management teams (SMTs), Governing Boards (GBs), health service providers and higher health sector offices with information to assist in measuring and monitoring hospital performance focusing on a core set of Key Performance Indicators and, conduct site visits and facilitate review meetings to ensure the effectiveness, efficiency and quality of services provided. The manual also provides detailed guidance's which are:

- To ensure that hospitals collect and analyze accurate KPI data and enhance continuous use of information for evidence based decision making.
- Provide guidance on how to gather, analyze, interpret and use performance information's.
- Provide a standardized definition of Hospital performance monitoring and Improvement;
- To identify areas for further improvements within hospitals where targeted support, by the Community, Government offices and other partners is deemed necessary.
- Provide guidance on planning and implementation of comprehensive hospital Performance monitoring and improvement activities.
- Create a culture of learning based on utilizing M&E information as a basis for decision making and accountability in management and governance
- To identify and disseminate best practice

1.4 Target Audience for the Manual

These manual is intended to assist actors in the health sector to gather, synthesize and analyze data and use this information to improve hospital performance.
The actors are:

1. National level: MOH agencies and directorates etc
2. Regional level: RHB/Zonal departments etc
3. Facility level: Hospital GB, SMT, Unit heads, service providers etc
4. Community level: community forums, public wing members etc

Section 2: A Framework for Hospital Performance Monitoring and Improvement

The principal methods of monitoring hospital performance used nationwide are regulatory inspection, client satisfaction surveys, supportive supervisions, regular hospital review meetings and summits, operational research/evaluation, internal assessments and statistical indicators, most of which have never been tested rigorously.

Current Hospital Performance Monitoring and Improvement has three principal methods:

1. The establishment, reporting and review of a core set of hospital KPIs;
2. Supportive supervision to hospitals,
3. Regular Review meetings
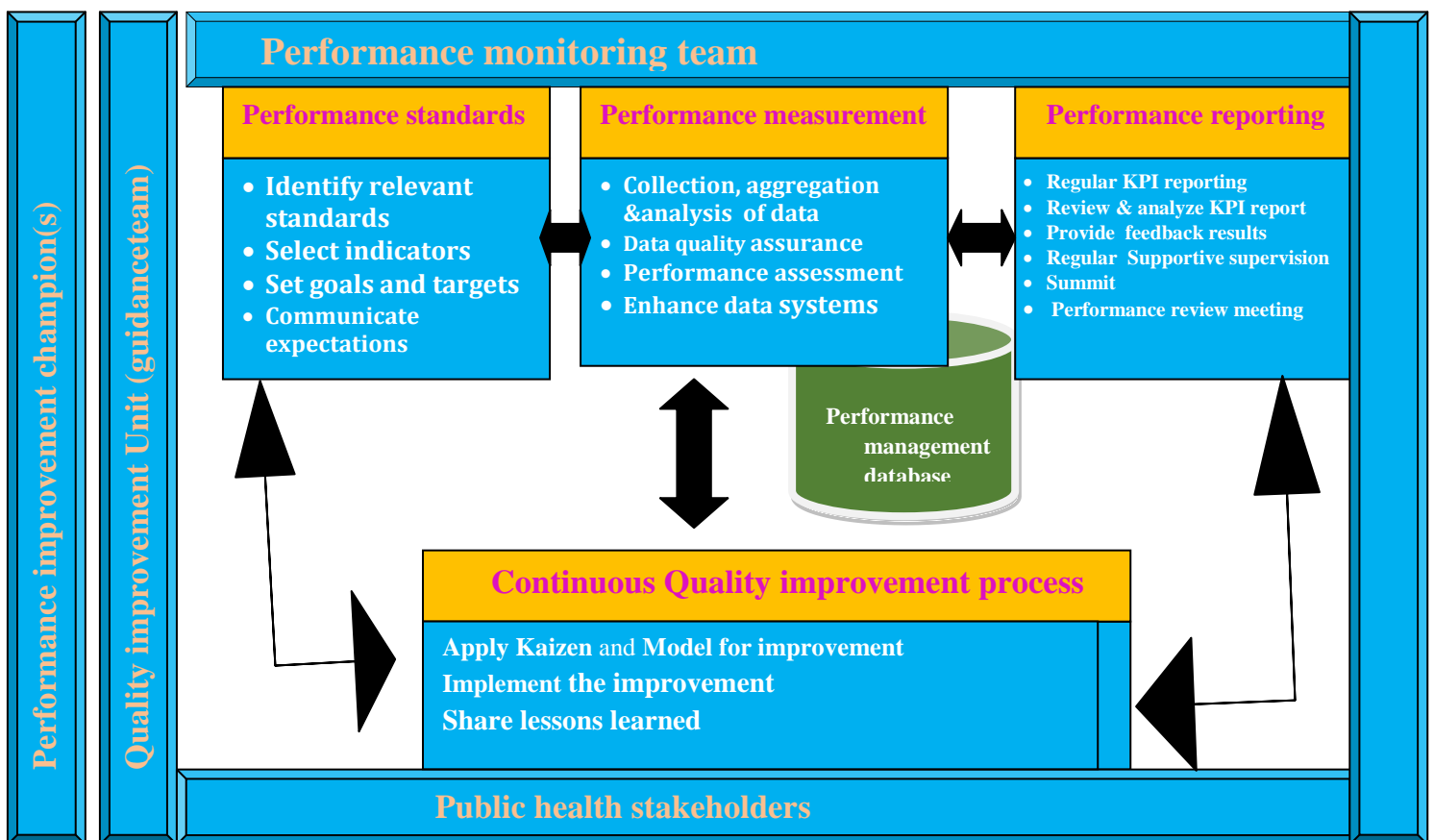
Figure 1: Framework for Hospital Performance Monitoring and Improvement (adapted from the Turning Point National Excellence Collaborative, 2003

Section 3: Hospital Key Performance Indicators (KPIs)

3.1 What are Key Performance Indicators?

An indicator is a variable that measures key elements of a health intervention, program, service, or project. Performance indicators are a popular mechanism for measuring the quality of healthcare to facilitate both quality improvement and systems management.[1]Indicators are used to track progress and evaluate change initiatives towards meeting an aim or objective.

Indicators are vital in health interventions because, when collected and used regularly, they can: provide a reference point for health intervention planning, management, and reporting, allow managers of health interventions to assess trends and identify problems and act as early warning signals for corrective action.

Different types of indicators are used for different purposes. For example indicators could be used to monitor implementation of a specific program, to monitor the financial performance of a hospital, to monitor the quality of care provided by each clinical team or to monitor hospital performance against its plan.

Instead of trying to monitor everything, SMT, Governing Board and other stakeholders need a core set of indicators that provide all the information they need to ensure that hospitals provide effective, efficient and quality services. These KPIs should describe the minimum information needed to effectively govern and manage hospital performance. KPs are a set of core hospital indicators that are used to identify whether Hospital performance is meeting desired standards and /or requires improvement. A common set of KPIs allow hospital performance to be tracked over time, and comparisons between hospitals and among regions.

The ZHD/RHB and FMOH should conduct regular review of Hospitals, Zonal and regional KPI's performance respectively, and identify areas where additional support is needed and should give timely feedback.

3.2   KPIs for Ethiopian hospitals

Currently there are total of 41 National KPIs (15 KPIs are integrated in Revised HMIS indicators reference guide) that were developed through series of consultation among the RHBs, FMOH and partners as the core set of indictors that form the foundation of the Hospital Performance Monitoring and Improvement Framework for Ethiopia.

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[1] NHS Institute for Innovation and Improvement, 2008

Twenty-Six (26) KPIs described in this manual are organized into11 categories under hospital management, outpatient services, emergency services, inpatient services, maternity services, pharmacy services, laboratory service, productivity, human resources, finance and clinical governance.

Hospital Management

KPI 1: % of Non-functional model medical equipment

KPI 2: CASH Audit score

Outpatient Services

KPI 3: Outpatient waiting time to Consultation

KPI 4: Outpatients not seen on same day

Emergency Services

KPI 5: Emergency room patients triaged within 5 minutes of arrival

KPI 6: Emergency room attendances with length of stay > 24hours

Inpatient Services

KPI 7: Delay for elective surgical admission

KPI 8: Pressure ulcer incidence

KPI 9: Surgical site infection rate

KPI 10: Completeness of inpatient medical records

KPI 11: Peri-operative Morality rate

KPI 12: Rate of safe surgery checklist utilization

KPI 13: Mean duration of in-hospital pre-elective operative stay

KPI 14: Surgical volume

KPI 15: Anesthetic adverse outcome

Maternity Service

KPI 16: Proportion of women Survived from PPH

KPI 17: Births by surgical, instrumental or assisted vaginal delivery

Pharmacy Services

KPI 18: Percentage of clients with 100% prescribed drugs filled

Laboratory Services

KPI 19: Essential Lab tests availability

KPI 20: Proportion of SLIPTA standard met

KPI 21: Blood unavailability ratio for surgical patients

Productivity

KPI 22: Outpatient clinical care productivity for physicians

KPI 23: Major surgeries per surgeon

Human resources

KPI 24: Staff satisfaction

Finance

KPI 25: Raised revenue spending as a proportion of total operating spending

Clinical governance

   KPI 26: Patient satisfaction

Key Performance Indicator (KPI) which is incorporated to revised HMIS (15 KPI)

   KPI 27: Institutional maternal deaths

   KPI 28: Still birth rate

   KPI 29: Early Institutional neonatal death rate

   KPI 30: Inpatient mortality rate

   KPI 31: Viral load suppression

   KPI 32: Health budget utilization

   KPI 33: Outpatient attendance per capita

   KPI34: Admission rate

   KPI 35: Bed occupancy rate

   KPI 36: Average length of stay

   KPI 37: Mortality rate in intensive care unit (ICU)

   KPI 38: Emergency unit/department mortality

   KPI 39: Referral rate

   KPI 40: Proportion of patient attendances for insurance beneficiaries

   KPI 41: Reimbursement ratio

3.3 KPIs Relationship with HMIS

The Health Management Information System (HMIS) draws its data from routine services and administrative records and it is primarily designed to monitor and refine implementation of the Health Sector Transformation Plans[2]. Additionally, the indicators are based on the priorities of the Plan for Accelerated and Sustained Development to End Poverty, the needs and priorities of local authorities and the requirements of international agreements, such as the Sustainable Development Goals.

On the other hand, the hospital KPIs are a small set of 43 indicators with the primary function of assisting hospital SMTs, Governing Boards, RHBs and FMOH to oversee hospital operations. The hospital KPIs and HMIS indicators should be reviewed together as some of KPIs are already integrated with existing HMIS and both HMIS and KPIs are already included in DHIS2 as separate modules.

3.4. Collecting Hospital KPI data

Hospitals should develop suitable mechanisms for collecting KPI /EHSTG/HSTQ data. These mechanisms should ensure that the information is accurate and that it has been properly checked prior to submission to next level. To achieve this, The Hospital should assign KPI focal person and respective data owner for each KPI for proper collection, analysis and reporting of KPI /EHSTG/HSTQ data.

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[2] FMOH (2015) HMIS/M&EIndicator Definitions: HMIS / M&E Technical Standards: Area 1.

3.4.1KPI Data Owners

The data owner should be an individual who is responsible for the primary data source (e.g. register, record or database) from which the KPI /EHSTG/HSTQ is drawn and who has responsibility for the service area that is being measured.

Each KPI data owner is responsible for:

- Maintenance of the primary data source(s) for KPI information
- Calculating the KPI, at the end of each reporting period
- Timely submit the KPI /EHSTG/HSTQ data to the KPI focal person
- Reviewing the KPI& selected standards and identify any action that is needed as a result (i.e. performance improvement plan)

For example, the Head of Human Resources (HR) department could be the KPI data owner for KPI24: Staff satisfaction

3.4.2. KPI focal person

A focal person should be assigned to collect all KPIs and the data elements from the data owners and prepare the hospital KPI /EHSTG/HSTQ report. The KPI focal person should be a member of the hospital quality committee and accountable to Quality unit head together with HMIS team. The KPI focal person should be the member of hospital performance review team. Any of HMIS team members who trained on KPI should also be assigned to act in the absence of the KPI focal person.

The KPI focal person is responsible for:

- Collecting KPI data from every KPI data owner at the end of the reporting period
- Checking the accuracy of the KPI /EHSTG/HSTQ data, by reviewing data sources and conducting spot checks for accuracy on the data sources and the KPIs submitted by data owners
- Entering the KPI/EHSTG/HSTQ data into the electronic Hospital KPI Database/DHIS2
- Preparing the KPI report (including data elements and KPI results) from the KPI Database
- Submit the KPI report to the hospital Clinical Governance and Quality Management Unit (CG&QMU) and CEO during the specified reporting period.
- Train and support the KPI data owners and other relevant staffs
- Ensuring the availability of all required computer hardware and software, stationery and formats for the collection and submission of KPIs.

3.5Analyzing and reporting Hospital KPI data

3.5.1Analysis and reporting at Hospital level

An electronic DHIS2 or Hospital KPI Database has been created (in Microsoft Excel spreadsheet) into which the KPI focal person should enter all KPI data elements. The KPI

Database will automatically generate KPI results and related tables and charts. KPI reports can be printed from this Database.

After entering and checking the data quality, the KPI focal person should print the KPI report and submit this to their CG&QMU and the CEO. The hospital CEO should review, check and sign the KPIs before submitting them to the Governing Board and next levels.

Additionally, KPI data should be submitted to the RHB. Ideally, the KPI focal person should regularly email the electronic KPI Database to the RHB. If this is not possible, the KPI focal person should print a copy of the data elements and a copy of the KPI results directly from the KPI Database and should fax these to the RHB.

Hospitals should also keep track of progress towards attainment of EHSTG standards. To assist with this, a Hospital EHSTG Database has been created into which the KPI focal person should enter all EHSTG self-assessment results. The EHSTG Database will automatically generate tables and charts from the entered data.

The KPI focal person should email an electronic copy of the EHSTG Database to the RHB every quarter. If this is not possible then a hard copy of the EHSTG self-assessment tool should be faxed to the RHB.

Table 1: KPIs reporting hierarchy of public health facilities, 2017

From	Reporting level	Report arrival date	Frequency of reporting	Comment
Primary Hospitals	**ZHD**	**26th of the month**	**Monthly, Quarterly & Annual**	
General hospitals/ZHD	**RHB**	**2nd of the month**	**Monthly, Quarterly & Annual**	
RHB	**FMOH**	**7th of the month**	**Monthly, Quarterly & Annual**	

3.5.2 Analysis and reporting at regional level

Each RHB should assign a focal person to receive KPI and EHSTG reports from all hospitals, and regional data should be aggregated and analyzed using electronic Regional KPI Database/DHIS2that it will automatically generate results and related tables and charts, including regional averages. Regional team should review the quality and regional performance before sending their KPI and EHSTG reports.

Every quarter, the RHB should email electronic copies of the Regional KPI Database and Regional EHSTG Database to FMOH. If it is not possible to send electronically then hard

copies of the KPI Data Elements and KPI Data Results and EHSTG together with a hard copy of the average attainment within the Region.

3.6. How should KPI reports be used?

Hospital KPI data should be used as information for action to guide decision making and planning for performance improvement at all levels. The performance improvement methods & tools presented in Section-2 above can be used, alongside KPI results, to determine actions to be taken to improve performance. Particular considerations for hospital management, staffs, Governing Boards, RHBs and the FMOH are outlined below.

3.6.1 Use of KPIs by Hospital management and staff

The data owner of each KPI is responsible not just for reporting the KPI data, but also for reflecting on the information and collaborating with colleagues to improve performance.

Useful questions to consider when reviewing KPI data include:

- How does this KPI result compare to the last reporting period?

- Is there improvement or change?

- How and why has the change in performance happened?

- How does the KPI compare to the target for the reporting period?

- Has the target been reached? If the target has not been reached and why?

- Is there a need for further improvement on this KPI?

- Is additional information required?

- Is further support (e.g. trainings, supervision) required from the RHB or other partners to support the hospital to make improvements?

The KPI data owner, together with case team and other relevant colleagues should analyze the performance and develop actions that need to be taken to improve performance. Each hospital should have a performance review team or Quality Unit and Quality Committee (QC) to oversee performance monitoring and improvement functions across the hospital. The Quality committee should be multidisciplinary, with members appointed from different clinical, administrative and supportive units within the hospital. The chair of the committee or Quality unit head should be a full time in their role and should be accountable to CEO as a member of the hospital senior management team and.

Roles of the Quality Unit include:

a) To develop hospital performance and/ quality management strategy and present to the Senior Management Team for approval,

b) To develop an implementation plan for the overall improvement of hospital performance and monitor its execution,

c) To ensure that performance management activities relate to the vision and mission of the hospital, and are aligned with the hospital strategic and annual plans,

d) To co-ordinate all hospital performance improvement activities,

e) To promote and support the participation of all staff in hospital performance improvement activities,

f) To receive and analyze feedback information from patients, staff and visitors,

g) To receive clinical audit reports and maintain a record of all clinical audit activities,

h) To review selected hospital deaths

i) To monitor KPIs and HMIS indicators

j) To conduct peer review in response to specific quality and safety concerns and to take appropriate action and follow-up when deficiencies are identified, and

k) To update hospital staff on hospital performance improvement activities and findings including:

    a) Comparisons across time

    b) Comparisons between case teams/departments

    c) Comparisons with other health facilities.

3.6.2 Use of KPIs by a Hospital Governing Board

Hospital Performance Reports should be presented to the Governing Board by the hospital CEO. The report should be circulated at least ones a week in advance of the Governing Board meeting, together with the agenda and any other discussion papers for the board meeting.

The Governing Board should discuss the report, identifying areas of improvement or weakness and set direction and specific follow up actions.

For example, if the Patient Satisfaction Score is low or is decreasing, the Governing Board could ask the CEO to present the full results of the Patient Satisfaction Survey to see if there are any particular areas of concern, and could also ask to describe actions that the hospital is going to take to improve patient satisfaction. Or, if inpatient mortality is high or increasing, the Governing Board could ask the CEO if there are any factors to explain this (perhaps a communicable disease outbreak) or to provide additional information on the mortality rate for

each ward or specialty (e.g. surgical mortality rate, pediatric mortality rate etc) to identify if there is a particular problem area.

When reviewing the hospital KPI data and discussing with the CEO, questions that Governing Board members should consider include:

- How does each KPI compare to the last reporting period?

   o If there is improvement, how did this take place? Should special recognition be given to any staff members or case teams who are responsible for the improvement?

   o If performance is worse why has this taken place?

   o How does each KPI compare to the target for the reporting period? Has the target been reached? If not, why not?

- What action should be taken by the CEO/hospital in response to the KPI results?

- What support (e.g. trainings, supervision) is required from the RHB or other partners to support the hospital to make improvements?

3.6.3 Use of KPIs by Regional Health Bureaus

After receiving hospital KPI and EHSTG reports and entering these into the Regional KPI and EHSTG/DHIS2 Databases, the RHBs should compare hospitals, monitor changes over time and calculate regional averages. The RHB should give feedback to each hospital on the KPI reports, asking for clarification or further information where required. The RHB should also use the hospital KPI reports to identify areas for action by the RHB. In particular, KPI reports should be used as input for hospital site visits and regional review meetings. When reviewing individual hospital KPI reports, the RHB should consider the same questions as outlined above for Governing Boards. In addition, the RHB should compare performance between hospitals, in particular:

- Which hospitals are showing the best and/or poor performance?

- What are the particular strengths and/or the weaknesses in the region?

3.6.4 Use of KPIs by HSQD

The HSQD assigned regional focal person to receive reports from all RHBs, review and send timely feedback to regions. Regional reports should be used nationally to monitor changes over time and to calculate national averages using electronic national KPI/EHSTG database or eDHIS2.

When reviewing regional KPI reports, HSQD should consider the same questions as RHBs. In addition, HSQD should compare performance between regions, in particular:

- Which regions are showing the best performance overall? Which are showing poor performance?

- Which regions are improving? Which regions show slow or no improvement?

- What are the common strengths in all regions, what are the common weaknesses?

HSQD should give feedback to each RHB on the KPI reports, asking for clarification or further information where required. HSQD should not contact hospitals directly in response to the KPI reports, but instead should discuss first with the RHB so that a joint response can be made to the hospital and any follow up action can be agreed jointly between FMOH and the RHB.

In particular, KPI reports should be used as input for hospital site visits and regional and national review meetings.

3.7 KPI Data Elements

The KPIs are calculated from individual data elements numbered Q1 to Q 62, which are listed below (Table 2). These data elements form the numerators and denominators of each KPI and, using the formulae, are used to calculate the 26 national KPIs.

Table 2: Summary of KPI Data Elements

Category	Code	Data Element
Hospital Management	Q1	Total number of Non-Functional Medical Equipment from the actual available list in the reporting period(Q1)
	Q2	Total number of Medical Equipment actually available in the reporting period(Q2)
	Q3	The total number of CASH audit tool standards met with Green
	Q4	The total number of CASH Audit tool standards
Outpatient Services	Q5	Sum total of outpatient waiting time (in minutes)
	Q6	Number of outpatient "waiting time cards "completed
	Q7	Number of outpatients not seen on same day as registration in OPD during the reporting period

	Q8	Number of new and repeat outpatient attendances at public facility
Emergency Services	Q9	Number of surveyed patients who undergo triage within 5 minutes of arrival in emergency room
	Q10	Number of patients included in emergency room during triage time survey
	Q11	Total number of admissions who remain in emergency room for more than 24 hrs
	Q12	Total number of emergency room admissions
Inpatient Services	Q13	Sum total of number of days between date added to surgical waiting list to date of admission for surgery
	Q14	Number of patients who were admitted for elective (non-emergency) surgery during the reporting period
	Q15	Number of inpatients who develop a new pressure ulcer during the reporting period
	Q16	Number of patients discharged alive (including transfers out)
	Q17	Number of deaths among admitted inpatients
	Q18	Number of inpatients with new surgical site infection arising during the reporting period
	Q19	Number of major surgeries (both elective & non-elective) performed during the reporting period on public patients
	Q20	Number of major surgeries (both elective & non-elective) performed during the reporting period on private wing patients
	Q21	Sum total of medical record checklist scores Yes (Q21)
	Q22	Number of discharged inpatient medical records surveyed x 6 (i.e. the number of items in checklist)
	Q23	Total number of deaths within 24 hour after surgery among patients who underwent a major surgical procedure in an OR
	Q24	Total number of deaths above 24 Hour prior to discharge among patients who underwent a major surgical procedure in an OR
	Q25	Total number of patients who received major surgery(both elective and non electives) in the reporting period
	Q26	Number of surgical patient charts in which the WHO Surgical Safety Checklist was completed per chart
	Q27	Total number of patient charts reviewed
	Q28	Total sum of pre-operative length of stay
	Q29	Total number of elective surgical procedures during the reporting period

	Q30	Number of surgical cases with anesthetic adverse outcome (high spinal anesthesia, failed intubation, cardio-respiratory arrest) during reporting period
Maternity Services	Q31	Number of Women who gave birth in the health facility or referred in who had any bleeding with hypotension or requiring blood transfusion and survived
	Q32	Total number of women who gave birth in the health facility or referred in or on arrival who had any bleeding with hypotension or requiring blood transfusion (survived or died)
	Q33	Number of Caesarean sections
	Q34	Number of abdominal surgical deliveries
	Q35	Number of instrumental or assisted vaginal deliveries
	Q36	Total deliveries (Number of live births attended in the hospital
	Q 37	Number of stillbirths attended in the hospital)
Pharmacy Services	Q38	Number of clients who received 100% of prescribed drugs
	Q39	Total number of clients who received prescriptions
Laboratory Services	Q40	Total number of days each essential laboratory tests are available in the hospital during the reporting period
	Q 41	Total number of hospital specific essential tests
	Q42	Total number of days in the reporting period
	Q43	Total SLIPTA audit standards met
	Q44	275 (i.e. total number of SLIPTA audit standards)
	Q45	Total number of referral plus Death plus cancelation of elective surgery due to blood shortage
	Q46	Total number of blood request to hospital mini blood bank
Productivity	Q47	Total number of FTE physicians assigned in outpatient department during the reporting period
	Q48	Number of major surgeries (both elective & non-elective) performed on public patients
	Q49	Number of major surgeries (both elective & non-elective) performed on private wing patients
	Q50	Average number of FTE specialist surgeons (excluding Ophthalmologists)
Human Resources	Q51	Total number of "Neutral" responses
	Q52	Total number of "satisfied" responses

	Q 53	Total number of staff Satisfaction surveys completed
	Q54	Total number of staff satisfaction criteria's evaluated
Health Financing	Q55	Operating spending retained revenue during reporting period
	Q56	Total operating expenditures for reporting period, i.e. operating budget spending from treasury for reporting period
Clinical Governance	Q57	Total number of "Neutral" responses
	Q58	Total number of "satisfied" responses
	Q59	Total number of Patient Satisfaction surveys completed
	Q60	Total number of patient satisfaction criteria's evaluated

3.8. Detailed guide to each KPI

The following tables present a detailed guide to each KPI, outlining the importance of the indicator, the data sources and formula for calculating the indicator.

(Please note: The detail about KPIs together with data entry formats for each KPI, are presented in Appendix 5. To be used and/or shared with the data owner of each KPI to assist with collection of the data elements and calculation of the KPI by the data owner).

Hospital Management KPIs

KPI 1: % of Non-Functional Model Medical Equipment

Why is this important?	Hospitals need to know the proportion of Medical Equipment's that are non-functional at any given time from their Model Medical Equipment List, MME they prepared. Model Medical Equipment List means, a list of equipment that describe the ideal types and number of equipment required by specific hospital that determined by multi-disciplinary team of the hospital. The indicator measures the effectiveness of services without interruption for diagnosis, therapeutics, prevention and investigation of the patient in the hospital due to failure of M/Es. It also helps to plan for maintenance or procurement of new essential medical equipment. For the RHB and FMOH, knowledge of the proportion of Non-Functional Medical Equipment in hospitals is necessary to plan and to take immediate action to procure, Maintain, install, calibrate and train on Medical equipment's. It can also help conduct national or regional maintenance and commissioning campaigns.
Definition	The proportion of Non-Functional Medical Equipment among available Medical Equipment in the hospital. • All Hospitals should prepare their ideal Model Medical Equipment List as per the tier level as a strategy and they shall work to fulfill according to the list on the basis of the hospital's service packages as stated in EHSTG (Chapter 15) • **Medical Equipment** defined as any instrument, apparatus, machine, appliance, implant, *in vitro* reagent or calibrator and software materials that are necessary to provide essential service in the hospital. • Based on the definition and the prepared ideal list, hospitals should decide which M/Es to be included and followed for its functionality. • As a new M/E procured, it will be included in the list and if a M/E transferred or disposed due to different reasons, it will be excluded from the denominator in a specific reporting period. • **Note:** All Medical Equipment in the hospital should be functional all the time.
Unit of measurement	%
Numerator	Total number of Non-Functional Medical Equipment from the actual available list in the reporting period(Q1)
Denominator	Total number of Medical Equipment actually available in the reporting period(Q2)
Formula	Total number of Non-Functional Medical Equipment (Q1)/ Total number of Medical Equipment in the hospital (functional **plus** non-

	functional)(Q2)*100
Data sources	Hospital Medical Equipment inventory of the reporting period Model Medical Equipment list Medical equipment history file
Frequency of reporting	Quarterly
Data entry	Calculation: KPI 1 $= \frac{Q1}{Q2} \; X \; 100 =$ _____%

KPI 2: CASH Audit Score

Why it is important?	Hospitals monitor their CASH performance regularly so as to identify their gaps and then improve continuously. Similarly regional health bureaus and federal ministry of health also monitor and evaluate CASH progress and this KPI will be a good monitoring indicator.
Definition	The proportion of CASH Audit tool standards met (Green) in the hospital. Green-For each standard if all criterion are met. Yellow-For each standard if $\geq$**50%** of the criteria are met. Red-For each standard if **<50%** of the criteria are met.
Unit of Measurement	%
Numerator	The total number of CASH audit tool standards met with Green(Q3)
Denominator	The total number of CASH Audit tool standards(Q4)
Formula	The total Number of CASH audit tool standards met with Green flag The total Number of CASH audit tool standards *100
Data sources	CASH audit tools
Frequency of reporting	Quarterly
Data entry	Q3: Total number of CASH audit tool standards met are available in the hospital during the reporting period= _____ Q4: Total number of CASH audit tool standards= _____ Calculation: The total Number of CASH audit tool standards met with Green flag(Q3) The total Number of CASH audit tool standards(Q4) *100 KPI 2 = Q3 *100% Q4

OUTPATIENT SERVICES
KPI 3: Outpatient waiting time to Consultation

Why is this important?	The time that a patient waits from arrival to treatment is a measure of access to health care services. Long waiting times indicate that there is insufficient staff and/or resources to handle the patient load or the available resources are being used inefficiently. By measuring waiting times a hospital can assess if there is a need • extra personnel and/or other resources in the outpatient department, • And/or a need to review patient flow processes to increase the efficiency of service provision.
Definition	Average time from arrival at the outpatient department to treatment consultation with clinical staff member (minutes) For patients who have an appointment and who go immediately to the OPD waiting area (without attending registration or triage), the time of arrival begins at the time when they reach the OPD waiting area. For patients who do not have an appointment, the time of arrival means the time of arrival at triage EXCLUDE: Patients not seen on the same day
Unit of measurement	Minutes
Numerator	Sum total of outpatient waiting time (in minutes) (Q5)
Denominator	Number of outpatient "waiting time cards "completed (Q6)
Formula	Sum total of outpatient waiting time (in minutes) (Q5) ÷ Number of outpatient "waiting time cards" completed (Q6)
Data sources	Survey – see protocol for survey to measure OPD wait time in Appendix 7 The survey should be conducted on Monday and Thursday of the first week of the last month of each quarter
Frequency of reporting	Quarterly
Data entry	Q5 = Sum total of outpatient waiting time (in minutes) = _____ Q6 = Number of outpatient waiting time cards completed =_____ Calculation: KPI 3 $= \frac{Q5}{Q6}\ minutes$

KPI 4: Outpatients not seen on same day

Why is this important?	All patients should be seen in the OPD on the same day that they register for treatment. By measuring the number and proportion of patients that do not receive a same day service, the hospital can assess if there is a need for extra personnel and/or other resources in the outpatient department and/or to review patient flow processes to increase the efficiency of service provision.
Definition	The proportion of all outpatients that do not receive treatment on the same day as the day of registration in the outpatient department
Unit of measurement	%
Numerator	Number of outpatients not seen on same day as registration in OPD during the reporting period (Q7)
Denominator	Number of new and repeat outpatient attendances at public facility (Q8) (No private wing ,public facility only)
Formula	Number of outpatients not seen on same day as registration during the reporting period (Q7) ÷Number of new and repeat outpatient attendances at public facility (Q8) x 100
Data sources	OPD registration book/ central triage book
Frequency of reporting	Quarterly
Data entry	Q8 = Number of new and repeat outpatient attendances at public facility = _____ Q7 = Number of outpatients not seen on same day as registration in OPD during the reporting period =_____ Calculation: KPI 4 $= \frac{Q7}{Q8} \; X \; 100 =$ _____%

EMERGENCY SERVICES

KPI 5: Emergency room patients triaged within 5 minutes of arrival

Why is this important?	Triage is a process of sorting patients into priority groups according to their need and available resources. The aim of triage is to give priority treatment to those with the most critical conditions, thus minimizing delay, saving lives, and making the most efficient use of available resources. The first five minutes of arrival in the emergency room (ER) is the most critical time to save lives. If assessment and treatment is not initiated during this time then lives will be lost unnecessarily. By monitoring the % of patients triaged within 5 minutes the hospital can assess whether ER services are sufficient and identify the need for additional staff and/or resources and/or service redesign to reduce waiting times in ER.
Definition	Proportion of all patients presenting to the emergency room who were seen by the triage officer within 5 minutes of arrival at the emergency room
Unit of measurement	%
Numerator	Number of surveyed patients who undergo triage within 5 minutes of arrival in emergency room (Q9)
Denominator	Number of patients included in emergency room during triage time survey (Q10)
Formula	Number of surveyed patients who undergo triage within 5 minutes of arrival in emergency room (Q9) ÷ Number of patients included in emergency room triage time survey (Q10) x 100
Data sources	Survey – see Appendix 8 : Protocol for survey to measure % of patients triaged within 5 minutes of arrival in ER . The survey should be conducted at 3 different time periods on the first week of the final month of each reporting period as follows: Monday: 8am to 12 noon Wednesday: 12 noon to 5pm Saturday: 5pm to 8am
Frequency	Quarterly
Data entry	Q9 = Number of surveyed patients who undergo triage within 5 minutes of arrival in emergency room =_____ Q10 = Number of patients included in emergency room during triage time survey =_____ Calculation: KPI 5 = $\frac{Q9}{Q10}$ X 100 = _____%

KPI 6: Emergency room attendances with length of stay > 24 hours

Why is this important?	Hospitals have emergency room beds where patients can stay for a short period of time to receive emergency treatment. However, the length of stay in the emergency room should always be less than 24 hours. If a patient requires treatment for longer than 24 hours then he/she should be transferred to a ward. If emergency room beds are occupied by patients for more than 24 hours then the emergency room will become congested and there is a danger that the emergency room will not have the capacity for any NEW emergency attendances.
Definition	The proportion of all emergency room admissions who remain in the emergency room for > 24 hours INCLUDE: • All patients registered in the emergency room (all ages) EXCLUDE: • Patients who were already dead (i.e. no vital signs present) on arrival
Unit of measurement	%
Numerator	Total number of admissions who remain in emergency room for more than 24 hrs (Q11)
Denominator	Total number of emergency room admissions (Q12)
Formula	Total number of admissions who remain in emergency room for more than 24 hrs (Q11) ÷ Total number of emergency room admissions(Q12) x 100
Data sources	Emergency room registration book
Frequency of reporting	Monthly
Data entry	Q12= Total number of emergency room admissions= _____ Q11= Total number of emergency room admissions who remain in emergency room for more than 24 hrs=_____ Calculation: KPI $6 = \frac{Q11}{Q12} X 100 =$ _____%

INPATIENT SERVICES
KPI 7: Delay for elective surgical admission

Why is this important?	Delays in surgery for different conditions are associated with a significant increase in morbidity and mortality. The Government has set a stretch objective that any outpatient who requires a bed should receive the service within 2 weeks. By monitoring the waiting time for surgical admission, hospitals can assess the adequacy of surgical capacity and identify the need for improved efficiency in systems and processes, and/or the need for additional surgical staff and/or resources.
Definition	The average number of days that patients who underwent elective surgery during the reporting period waited for admission (i.e. the average number of days between the date each patient was added to the waiting list to their date of admission for surgery
Unit of measurement	Days
Numerator	Sum total of number of days between date added to surgical waiting list to date of admission for surgery (Q13) EXCLUDE: Elective Caesarean Sections Emergency Surgery Ophthalmic Surgery NB: If a cold case patient is admitted on the same day (the same calendar date) that the decision for surgery is made then their number of days on the waiting list should be counted as zero.
Denominator	Number of patients who were admitted for elective (non-emergency) surgery during the reporting period (Q14)
Formula	Sum total of number of days between date added to surgical waiting list to date of admission for surgery (Q13) ÷ Number of patients who were admitted for elective (non-emergency) surgery during the reporting period (Q14)
Data sources	Liaison registration book,
Frequency of reporting	Monthly
Data entry	Q13 = Sum total of number of days between date added to surgical waiting list to date of admission for surgery = _____ Q14 = Number of patients who were admitted for elective (non-emergency) surgery during the reporting period = _____ Calculation: KPI 7 $= \frac{Q13}{Q14} =$ _____$days$

KPI 8: Pressure ulcer incidence

Why is this important?	This is an indicator of the quality of care performed by nursing staff in a hospital. Poor nursing care, with inadequate turning of patients in their bed can lead to the development of a pressure ulcer (also called bed ulcer or decubitus ulcer). Pressure ulcers can be fatal when allowed to progress without treatment. By measuring the pressure ulcer rate hospitals can assess the quality of nursing care provided and take action to address any problems identified.
Definition	Proportion of inpatients that develop a pressure ulcer during their hospital stay. Pressure ulcers arise in areas of unrelieved pressure (commonly sacrum, elbows, knees or ankles). <u>Either</u> of the following criteria should be met: • A superficial break in the skin (abrasion or blister) in an area of pressure OR • An ulcer that involves the full thickness of the skin and may even extend into the subcutaneous tissue, cartilage or bone INCLUDE: • New pressure ulcers that arise during the patients admission, during the reporting period EXCLUDE: • Pressure ulcers that were already present at the time of admission • Pressure ulcers that developed in a previous reporting period
Unit of measurement	%
Numerator	Number of inpatients who develop a new pressure ulcer during the reporting period (Q15)
Denominator	Number of patients discharged alive (including transfers out) (Q16) + Number of deaths among admitted inpatients (Q17)
Data sources	IPD register **
Frequency of reporting	Monthly
Frequency of reporting	Monthly
Data entry	Q17= Total number of patients discharged alive (including transfers out = _____ Q16= Total number of patients discharged alive (including transfers out) = _____ Q15= Total number of inpatients who develop a new pressure ulcer during the reporting period = _____ Calculation: KPI 8 $= \frac{Q15}{Q17 + Q16} X\ 100 =$ _____%

**NB. The PRESUR ULCER data always recorded on IPD registry at the remark part.

KPI 9: Surgical site infection rate

Why is this important?	Infection at the site of surgery may be caused by poor infection prevention practices in the operating room or on the ward after completion of surgery. The surgical site infection rate is an indicator of the quality of medical care received by surgical patients and an indirect measure of infection prevention practices in the hospital. By monitoring surgical site infection hospitals can assess the adequacy of infection prevention practices in the hospital and take action to address any problems identified.
Definition	Proportion of all major surgeries with an infection occurring at the site of the surgical wound *prior to discharge*. One or more of the following criteria should be met: • Purulent drainage from the incision wound • Positive culture from a wound swab or aseptically aspirated fluid or tissue • Spontaneous wound dehiscence or deliberate wound revision/opening by the surgeon in the presence of: pyrexia > 38C or localized pain or tenderness or redness/heat • An abscess or other evidence of infection involving the deep incision that is found by direct examination during re-operation, or by histopathological or radiological examination ➤ A major surgical procedure is defined as any procedure conducted in an OR under general, spinal or major regional anesthesia.
Unit	%
Numerator	Number of operated inpatient with new surgical site infection arising before discharge (Record at discharge) (Q18) INCLUDE: • Patients undergoing surgery in public facility • Private wing surgical cases
Denominator	Number of operated inpatients discharged alive (including transfers out) (Q19) + Number of operated inpatients discharged dead during the reporting period (Q20)
Formula	Number of operated inpatient with new surgical site infection arising before discharge (Record at discharge) (Q18) ÷ [Number of operated inpatients discharged alive (including transfers out) (Q19) + Number of operated inpatients discharged dead during the reporting period (Q20)] x 100.
Data sources	IPD registration
Frequency	Monthly
Data entry	Q18= Total number of inpatients with new surgical site infection arising during the reporting period = _____ Q19= Total number of major surgeries (both elective & non-elective) performed during the reporting period on public patients = _____ Q20= Total number of major surgeries (both elective & non-elective) performed during the reporting period on private wing patients = _____ Calculation: KPI 9 $= \frac{Q18}{Q19+ Q20} X\ 100 =$ _____%

NB: The IPD nurses will record the SSI data on the remark column of the IPD Registry. The ward physician is responsible for recording absence or presence of SSI on the discharge summary.

KPI 10: Completeness of inpatient medical records

Why is this important?	Complete and accurate medical records are essential to maintain the continuity of patient care and ensure that the health provider has full information about the patient when providing healthcare. Through HMIS a standardized medical record has been introduced nationwide. The completeness of this medical record is a measure of the quality of care provided at the hospital.
Definition	Proportion of elements completed of the minimum elements of an inpatient medical record. The MINIMUM elements are*: - Patient Card (Physician notes) – present and all entries signed - Progress note – documented at least once a day throughout the hospital stay - Order Sheet – Present and revised daily - Nursing Care Plan – Present, revised at least daily; V/S taken at least QID for all admitted patients - Medication Administration Record – present and all medications given are signed - Discharge Summary – present and signed - Clinical pharmacist record chart present and signed * The checklist describes the MINIMUM set of documents that should be present in the medical record of EVERY discharged patient. Some inpatient records will contain additional documents and forms (e.g. referral forms, laboratory report forms etc). However for standardization of this indicator, only the items that are listed in the checklist should be included in the survey.
Unit of measurement	%
Numerator	Sum total of medical record checklist scores Yes (Q21)
Denominator	Number of discharged inpatient medical records surveyed (Q22) x 7 (i.e. the number of items in checklist)
Formula	Sum total of medical records checklist scores Yes(Q21)/ Number of discharged inpatient medical records surveyed (Q22) x 7 (i.e. the number of items in checklist)*100
Data sources	Audit of medical records against checklist A full protocol for the audit is presented in Appendix 4 5% or 50 (whichever is greater) medical records should be audited
Frequency of reporting	Quarterly
Data entry	Q21 = Sum total of medical record checklist scores = _____ Q22 = Number of discharged inpatient medical records surveyed = _____ KPI 10 = $\dfrac{Q21}{Q22}$ * 100%

KPI 11: Peri-operative Mortality

Why is this important?	Surgical and anesthesia safety is an integral component of care delivery; peri-operative morality encompasses deaths in the operating theatre and in the hospital after the procedure. Informs policy and planning regarding surgical and anesthesia safety, as well as surgical volume when number of procedures is the denominator
Definition	All-cause death rate prior to discharge among patients who underwent a major surgical procedure in an operating theatre during the reporting period in the reporting health facility. Stratified by emergent and elective major surgical procedures. Exclusion: exclude patients operated in another facility unless re-operated in the reporting facility.
Unit of measurement	Percentage
Numerator	Total number of deaths before discharge within 24 hour after surgery among patients who underwent a major surgical procedure in an OR(Q23)+ Total number of deaths before discharge but more than 24 Hours post op among patients who underwent a major surgical procedure in an OR(Q24)
Denominator	Total number of patients who received major surgery(both elective and non electives) in the reporting period(Q25)
Formula	Total number of deaths before discharge within 24 hour after surgery among patients who underwent a major surgical procedure in an OR((Q23))+ Total number of deaths before discharge but more than 24 Hours post op among patients who underwent a major surgical procedure in an OR (Q24)/Total number of patients who received major surgery(both elective and non electives) in the reporting period(Q25)
Data sources	OR Registry and All IPD registers
Frequency of reporting	Monthly
Data entry	KPI 11= $\dfrac{Q23+ Q24}{Q25}$ *100%

KPI 12: **Rate of safe surgery checklist utilization**

Why is this Important?	A long in hospital pre op stay results in unnecessary bed occupancy as well as increase the risk of colonization by antibiotic resistant hospital flora. It is indicative of insufficient pre admission preparation or inefficient OT management resulting in cancellations. These will be highlighted for intervention by monitoring this indicator
Why is this important?	Safe surgery checklist a safety checks that could be performed in any operating room. It is designed to reinforce accepted safety practices and foster better communication and teamwork between clinical disciplines. The Checklist is intended as a tool for use by clinicians interested in improving the safety of their operations and reducing unnecessary surgical deaths and complications. This is an important aid to ensure patient safety.
Definition	Proportion of surgical cases where the WHO safe surgery check list was fully implemented.
Unit of measurement	Percentage
Numerator	Number of Major surgical patient charts in which the WHO Surgical Safety Checklist was completed per chart(Q26)
Denominator	Total number of patient charts reviewed (Q27) ➢ 50 charts
Formula	Number of surgical patient charts in which the WHO Surgical Safety Checklist was completed patient chart (Q26) / Total number of patient charts reviewed (Q27) x 100
Data sources	Survey Patient Chart
Frequency of reporting	Monthly
Data entry	KPI 12= $\dfrac{Q26}{Q27}$ * 100%

Definition	The average number of days patients waited in-hospital (after admission) to receive elective surgery during the reporting period.
Unit of measurement	Number
Numerator	Total sum of pre-operative length of stay (Q28)
Denominator	Total number of elective surgical procedures during the reporting period (Q29)
Formula	Total sum of pre-operative length of stay (Q28) / Total number of elective surgical procedures during the reporting period (Q29) x 100
Data sources	OR Registry
Frequency of reporting	Monthly
Data entry	KPI 13= $\dfrac{Q28}{Q29}$ *100%

KPI 13: Mean duration of in-hospital pre-elective operative stay

KPI 14 :Surgical volume

Why is this important?	The number of surgical procedures done is an indicator of met need. With the high surgical need of the population, this indicator will show progress across time. Informs policy and planning regarding met and unmet need for surgical service.
Definition	Total number of major surgical procedures performed in operating theatre

	per month. Major surgery is defined as a procedure performed under general anesthesia, regional anesthesia in an OR.
Unit of measurement	Number
Numerator	Total number of major surgical procedures performed in OR per reporting period (Q25)
Denominator	None
Formula	Total number of major surgical procedures performed in OR per reporting period (Q25)
Data sources	OR Registry
Frequency of reporting	Monthly
Data entry	KPI 14 = Q25

KPI 15: Anesthetic adverse outcome

Why is this important?	A large component of the difference in mortality after surgery between developed and LMIC is caused by differences in anesthesia mortality. The rate of anesthetic adverse outcomes assesses the safety and quality of anesthesia service.
Definition	Percentage of surgical patients who developed any one of the following: 1. Cardio respiratory arrest 2. Inability to secure airway 3. High spinal anesthesia **Cardio-respiratory arrest as**: cessation of cardiac activity as evidenced by: ▪ Chest compressions being performed ▪ Loss of femoral, carotid and apical pulse with ECG changes **High spinal** defined as: Within 15 minutes of administration of spinal anesthesia: ▪ Patient experiences loss of sensation in the shoulder AND ▪ Need for positive pressure ventilation after administration of spinal anesthesia Includes any administration of spinal anesthesia extending above T4 level. **Inability to secure airway** defined as: ▪ Having to awaken patient due to inability to intubate ▪ Cardio-respiratory arrest due to failure to intubate
Unit of measurement	Percentage
Numerator	Number of surgical cases with anesthetic adverse outcome (high spinal anesthesia, failed intubation, cardio-respiratory arrest) during reporting period(Q30)
Denominator	Total number of major surgical procedures performed in OR during reporting period(Q25)
Formula	Number of surgical cases with anesthetic adverse outcome (high spinal anesthesia, failed intubation, cardio-respiratory arrest) during reporting period(Q30)/ Total number of major surgical procedures performed in OR during reporting period(Q25) x 100
Data sources	Anesthesia Registry
Frequency of reporting	Monthly
Data entry	KPI 15= $\dfrac{Q30}{Q25}$ *100%

MATERNITY SERVICE

KPI 16: Proportion of women Survived from PPH

Why is this important?	This indicator measures quality of care provided to women in the immediate post-partum period and an indirect measure of timely response for early identification and managing the incidence of PPH. By monitoring the management of PPH hospitals can review all possible causes and take action to address any problems identified.
Definition	Women who gave birth in the health facility or referred in who had any bleeding with hypotension or requiring blood transfusion INCLUDE: All PPH cases diagnosed in the health institution/ on arrival/ referred in EXCLUDE: Dead on arrival of PPH cases
Unit of measurement	%
Numerator	Number of Women who gave birth in the health facility or referred in who had any bleeding with hypotension or requiring blood transfusion and survived (Q31)
Denominator	Total number of women who gave birth in the health facility or referred in or on arrival who had any bleeding with hypotension or requiring blood transfusion or died (Q32) + Number of Women who gave birth in the health facility or referred in who had any bleeding with hypotension or requiring blood transfusion and survived (Q31)
Formula	Total Number of Women who gave birth in the health facility or referred in who had any bleeding with hypotension or requiring blood transfusion and survived (Q31) ÷ Total Number of women who gave birth in the health facility or referred in who had any bleeding with hypotension or requiring blood transfusion (survived or died) during the month (Q32)x 100
Data sources	Delivery register/ postnatal register/maternity register/ICU register/OR register
Frequency of reporting	Monthly
Data entry	Q31= Total Number of Women who gave birth in the health facility or referred in or on arrival who had any bleeding with hypotension or requiring blood transfusion and survived during the month) = _____ Q32= Total Number of women who gave birth in the health facility or referred in or on arrival who had any bleeding with hypotension or requiring blood transfusion or died during the month = _____ Calculation: KPI 16 $= \frac{Q31}{Q31+Q32} X\ 100 =$ _____%

KPI 17: Births by surgical, instrumental or assisted vaginal delivery

Why is this important?	In the health care system of Ethiopia, it is expected that hospitals will manage complicated maternity cases and that uncomplicated pregnancies and normal deliveries should mainly be managed by Primary Health Care Units. By monitoring the % of attended deliveries that are complicated, the hospital and RHB can assess if hospital services are being used appropriately.
Definition	Number of births by surgical, instrumental or assisted vaginal delivery per 100 deliveries attended in the hospital Caesarean Section means delivery of the fetus (including live births and stillbirths) by the abdominal route when the uterus is intact (Q33) Abdominal Surgical Delivery means removal of the fetus, placenta and/or membranes by the abdominal route (including live births and stillbirths) where the uterus is not intact (i.e. ruptured uterus). (Q34) Instrumental or assisted vaginal delivery (Q35) means any vaginal delivery (including live births and stillbirths) using an instrument or manual intervention of the health worker. INCLUDE: • Forceps delivery • Rotational deliveries, e.g. internal podalic version • Assisted breech delivery • Vacuum extractions • Craniotomy EXCLUDE: Episiotomy • Vaginal tears
Numerator	Number of Caesarean sections (Q33) + Number of abdominal surgical deliveries (Q34) + Number of instrumental or assisted vaginal deliveries (Q35)
Denominator	Total deliveries (Number of live births attended in the hospital (Q36) + Number of stillbirths attended in the hospital) (Q37)
Unit of measurement	%
Formula	[Number of Caesarean sections (Q33) + Number of abdominal surgical deliveries (Q34) + Number of instrumental or assisted vaginal deliveries (Q35)] ÷ Total deliveries [Number of live births attended in the hospital (Q36) + Number of stillbirths attended in the hospital (Q37)] x 100
Data sources	Delivery registration book
Frequency of reporting	Monthly
Data entry	Q36 = Total number of live births attended in the hospital = _____ Q37 = Total number of stillbirths attended in the hospital = _____ Q33 = Number of Caesarean sections = _____ Q34 = Number of abdominal surgical deliveries = _____ Q35 = Number of instrumental or assisted vaginal deliveries = _____ KPI 17 = $\dfrac{Q33+ Q34 + Q35}{Q36 + Q37} \times 100$ = --------%

PHARMACY SERVICE

KPI 18: Percentage of Clients with 100% prescribed drugs filled

Why is this important?	Percentage of clients who get all of the prescribed drugs (100%) from dispensary is an indicator of access to quality and affordable medicines. Proportion of clients who get all the prescribed drugs is one of the indicators that tell about the continuous availability of drugs and quality pharmaceutical care in country. Getting prescribed drugs within the facility pharmacy improves patient satisfaction and overall trust and confidence in the health sector. Percentages of clients who get all the prescribed drugs (100%) from dispensary are expected to be 100 percent.
Definition	Percentage of clients who get all of the prescribed drugs (100%) from dispensary among all the clients who received prescriptions in a given time period.
Unit of measurement	%
Numerator	Number of clients who received 100% of prescribed drugs(Q38)
Denominator	Total number of clients who received prescriptions(Q39)
Formula	Number of clients who received 100% of prescribed drugs(Q38)/Total number of clients who received prescriptions(Q39)*100
Data sources	Survey of patient chart and Rx of dispensed medicines
Frequency of reporting	Quarterly
Data entry	Q38 = Number of clients who received 100% of prescribed drugs = _____ Q39 = Total number of clients who received prescriptions = KPI 18 $= \frac{Q38}{Q39} X\ 100 =$ _____%

LABORATORY SERVICE

KPI 19: Essential laboratory tests availability

Why is this important?	The availability of hospital specific essential laboratory tests is a measure of service availability. Essential tests should ALWAYS be available at the hospital. If one of these tests is unavailable at any time, the hospital should take action to identify and address the cause. For the RHB, knowledge of the availability of hospital specific essential laboratory tests in hospitals helps to assess the adequacy of access to laboratory tests and helps to address issues of good governance.
Definition	The number of days in which all hospital specific essential laboratory tests were available in the reporting period. NB: Hospitals are required to avail the minimum laboratory tests recommended by Food, Medicine and Healthcare Administration and Control Authority standards at all times.
Unit of measurement	Percentage
Numerator	Total number of days each essential laboratory tests are available in the hospital during the reporting period (Q40)
Denominator	Total number of hospital specific essential tests (Q41) X Total number of days in the reporting period (Q42)
Formula	∑days available (Q40) ÷ [∑tests (Q41) x ∑total number of days in time period (Q42)] x 100
Data sources	Hospitals should introduce and use as data source, Unavailable test log sheet.
Frequency of reporting	Monthly
Data entry	Q40: Total number of days each essential laboratory tests are available in the hospital during the reporting period= _____ Q41: Total number of hospital specific essential tests = _____ Q42:Total number of days in the reporting period = 30 Calculation: KPI 19 $= \frac{Q40}{Q41 \ X \ Q42} X \ 100 =$ _____%

KPI 20: Proportion of SLIPTA standards met

Why is this important?	The Stepwise Laboratory (Quality) Improvement Process Towards Accreditation (SLIPTA) is a framework for improving quality of Hospital laboratories to achieve ISO 15189 standards.
	Laboratory audits are an effective means to;
	  1) determine if a laboratory is providing accurate and reliable results;
	  2) determine if the laboratory is well-managed and is adhering to good laboratory practices; and
	  3) Identify areas for improvement.
	This quality improvement process towards accreditation further provides a learning opportunity and pathway for continuous improvement, a mechanism for identifying resource and training needs, a measure of progress,
	It is a five star tiered approach, audit of laboratory operating procedures, practices, and performance. There are a total of 275 points across 12 sections:

Definition	The percentage of SLIPTA audit scored
Unit of measurement	%
Numerator	Total SLIPTA audit standards met (Q43)
Denominator	275 (i.e. total number of SLIPTA audit standards) (Q44)
Formula	Total SLIPTA audit standards scored (Q43) ÷ 275 (i.e. total number of SLIPTA audit standards) (Q44)
Data sources	Assessment tool for Stepwise Laboratory (Quality) Improvement Process Towards Accreditation (SLIPTA)
Frequency of reporting	Biannual
Data entry	Q43 = Total SLIPTA audit standards met = _____ Q44= 275 (i.e. total number of SLIPTA audit standards) Calculation: $KPI\ 20 = \frac{Q43}{Q44\ (275)} X\ 100 = $ _____%

KPI 21: Blood unavailability ratio for surgical patients

Why is this important?	Timely access to blood is a factor in surgical morbidity and mortality especially in obstetric and trauma care where hemorrhage is a major cause of mortality.
Definition	The ratio of major surgical/obstetric cases which are referred or cancelled because of unavailability of blood to major surgical procedures in the reporting period.
Unit of measurement	Ratio
Numerator	Total number of major surgical/obstetric procedures cancelled or referred because of lack of blood for transfusion(Q45)
Denominator	Total number of surgical patients for whom cross - match was done (Q46)
Formula	Report as a ratio(E.g. 1:2)
Data sources	OR Registry, IPD register, Liaison office record
Frequency	Monthly
Data entry	KPI 21 = Q45 : Q46

PRODUCTIVITY

KPI 22: Outpatient clinical care productivity for physicians

Why this is important?	This indicator relates to the productivity of physicians and helps the hospital to determine whether physicians are underproductive, productive, or are overloaded. Accordingly, the indicator will be related with other indicators like OPD waiting time to treatment and patients not seen on the same day, and if quality gaps are identified the productivity will be analyzed in relation to other resource gaps including planning to increase physician number if they are already overloaded or planning for more clinic numbers or accountability systems if the physicians are underproductive. For teaching hospitals, the estimated allocation of time for clinical care, teaching learning process and research activities is 40%, 40% and 20% respectively. Accordingly, interpretation of productivity takes this in to consideration with due consideration of specific period of the report. For instance, the clinical care engagement should be adjusted more than 40% if the physicians are not engaged in research activities in that particular reporting period. The same applies for teaching learning activities if the actual number of consultants is in excess of the need to run the regular schedule of academic activities.
Definition	Clinical care productivity for physicians is the average number of patients managed by full time equivalent (FTE) physicians. A FTE physician is the one who worked for at least 8 hours a day (except Friday in which case it is 7 hours), 5 days a week and 4 weeks of the reporting period. If a physician works only part of the reporting period then his/her regular work hours should be converted to a FTE number by dividing the number of regular working hours by 39. For instance, if he/she was productive only for 2 weeks, then the FTE will be 0.5 and 0.75 if he/she was productive for 3 weeks.
Unit	number
Numerator	Total number of outpatients managed in the reporting period during regular working hours (Q8). INCLUDES: all outpatient clinic visits (new and repeat) in the reporting period during regular working hours. EXCLUDES: all outpatient clinic visits (new and repeat) seen in the private wing and all emergency patients
Denominator	Total number of FTE physicians assigned in outpatient department during the reporting period(Q47)

| | INCLUDES: all interns, GPs, all years of Residency, consultants who are appointed by the government or are voluntary or funded by another source |
	EXCLUDES: Interns, GPs, Residents, Consultants who are assigned in the outpatient department but not physically available during all days of the reporting period for private or hospital related missions.
Formula	Total number of outpatients managed in the reporting period during regular working hours (Q8) ÷ Total number of FTE physicians assigned in outpatient department during the reporting period(Q47)
Data source	Outpatient registration book/register, HR database or intern/resident assignment schedule
Frequency	Monthly
Data entry	Q 8:Total number of outpatients managed in the reporting period during regular working hours
	Q 47: Total number of FTE physicians assigned in outpatient department during the reporting period.
	Calculation: $KPI\ 22 = \frac{Q8}{Q47}$

KPI 23: Major surgeries per surgeon

Why is this important?	This indicator relates to the productivity of surgeons, and helps the hospital to determine whether surgeons are working productively, or are overloaded. The indicator is useful for planning future surgical staff numbers. Definition
Definition	The number of major surgical procedures per full time equivalent (FTE) specialist surgeon.
Numerator	Number of major surgeries (both elective & non-elective) performed on public patients (Q48) + Number of major surgeries (both elective & non-elective) performed on private wing patients (Q49) A major surgical procedure is defined as any procedure conducted under general, spinal or major regional anesthesia. INCLUDE: • all major surgeries conducted on patients admitted to public facility • all surgeries conducted on private wing patients EXCLUDE: all ophthalmic surgery NB: Ophthalmologists and ophthalmic surgery should be excluded because the case mix of ophthalmic surgeons is substantially different from that of other surgeons. In particular, ophthalmic surgery tends to be of shorter duration than other types of surgery and hence inclusion of ophthalmic surgery in the calculation would introduce bias when comparing hospitals that provide an ophthalmic service with those that do not.
Denominator	Average number of FTE specialist surgeons (excluding Ophthalmologists) (Q50) Specialist surgeons INCLUDE: • All surgeons funded by the hospital or RHB • All surgeons who are voluntary or funded by another source • Surgical residents (R-II and above – general, OB/GY, Orthopedic,etc) • IESO EXCLUDE: • Ophthalmologists
Formula	[Number of major surgeries (both elective & non-elective) performed on public patients (Q48) + Number of major surgeries (both elective & non-elective) performed on private wing patients (Q49)] ÷ Average number of FTE specialist surgeons (excluding Ophthalmologists) (Q50)
Data sources	Surgical/operating room log book Human resources/personnel database
Frequency of	Monthly

reporting	
Data entry	Q48= Total number of major surgeries (both elective & non-elective) performed on public patients = _____ Q49= Total number of major surgeries (both elective & non-elective) performed on private wing patients = _____ Q50= Average number of FTE specialist surgeons (excluding Ophthalmologists) = _____ Calculated:

HUMAN RESOURCE

KPI 24: Staff satisfaction

Why is this important?	Hospitals should strive to provide a good working environment for employees, with opportunities for training and development and equitable remuneration. Employees who are satisfied with their working environment are more productive and provide higher quality care. In contrast when workers are dissatisfied in the workplace their productivity tends to be low and the attrition rate is high. The Satisfaction of Employees in Healthcare (SEHC) survey has been developed for use in Ethiopian health facilities. The survey tool measures staff experience and perceptions in relation to training and development opportunities, communication and relationships between staff members, provision of adequate resources to perform the job, and the overall rating of the hospital as a working environment. By monitoring staff satisfaction, the hospital can identify areas for improvement and take action to address problems identified.
Definition	Proportion of "neutral and satisfied" staff responses among all staff surveyed in the specified period.
Unit	Percentage
Numerator	Total number of " Neutral" responses (Q51)+ Total number of " satisfied" responses (Q52)
Denominator	total number of staff Satisfaction surveys completed(Q53) x total number of staff satisfaction criteria's evaluated (Q54)
Formula	[[Total number of "Neutral" responses(Q51) + Total number of "satisfied" responses(Q52)] / [total number of staff Satisfaction surveys completed(Q53) x total number of staff satisfaction criteria's evaluated (Q54)]] x 100%
Inclusion cri.	The survey should also include interns, residents, other staffs seconded by other organizations.
Exclusion cr.	6 months or less since a staff joined the hospital
Data sources	Survey – For the survey tool and protocol – see Appendix 10
Frequency	Biannually
Data entry	Q51= Total number of "Neutral" responses = _____ Q52= Total number of "satisfied" responses = _____ Q53= Total number of staff Satisfaction surveys completed = _____

	Q54= Total number of staff satisfaction criteria's evaluated] = _____

HEALTH FINANCEING

KPI 25: Raised revenue as a proportion of total operating spending

Why is this important?	Hospital income is generated from two sources: government budget allocation (treasury) and raised revenue. Through Healthcare Finance Reform (HCFR) hospitals now have the autonomy to generate income from user fees, private wing and other sources. This is known as raised revenue. Hospitals are expected to generate income that should then be re-invested in the hospital to improve the quality of services provided. By monitoring the amount of raised revenue expenses and the ratio between raised revenue spending and total operating expenditure the hospital can assess the adequacy of HCF activities and plan future service improvements.
Definition	Raised revenue as a proportion of total operating expenditure (i.e. raised revenue operating + Treasury operating) for the reporting period
Unit of measurement	%
Numerator	Operating retained revenue during reporting period (Q55)
Denominator	Total operating expenditures for reporting period, i.e. operating budget from treasury for reporting period (Q56) + Operating retained revenue during reporting period (Q55) *operating budget spending from treasury for reporting period means budget spent for the general running of a hospital (including, consumables and supplies etc). Staff salaries, allowance for personnel and capital budget allocation should be EXCLUDED.*
Formula	Operating retained revenue during reporting period (Q55) ÷ [Total operating budget expenses for reporting period (Q56+Q55)] * 100 %

Data sources	Hospital financial statement
Frequency of reporting	Quarterly

CLINICAL GOVERNANCE

KPI 26: Patient satisfaction

Why is this important?	Patient satisfaction with the health care they receive at the hospital is a measure of the quality of care provided. By monitoring patient satisfaction hospitals can identify areas for improvement and ensure that hospital care meets the expectations of the patients served. Patient satisfaction survey tool have been developed for use in Ethiopian health facilities. These survey tool measure the patient experience related to service availability, cleanliness, communication, respect, medication (prescription, availability and patient information) and cost in OPD, IPD, maternity and emergency departments.
Definition	Proportion of "neutral and satisfied" client responses among all clients surveyed in the specified period.
Unit of measurement	Percentage
Numerator	Total number of " Neutral" responses (Q57) + Total number of " satisfied" responses (Q58)
Denominator	total number of Patient Satisfaction surveys completed(Q59) x total number of patient satisfaction criteria's evaluated (Q60)
Formula	[[Total number of "Neutral" responses (Q57) + Total number of "satisfied" responses (Q58)] / [total number of Patient Satisfaction surveys completed (Q59) x total number of patient satisfaction criteria's evaluated (Q60)]] x 100%

Data sources	Survey – protocol for the patient satisfaction survey is presented in Appendix 8. A minimum of 120 patient (30 from each of departments; OPD, IPD, maternity and ED). Data entry and analysis can be undertaken using the electronic Access database and Excel pre-programmed analytical tool through which summary tables, charts and the average satisfaction rating can be calculated.
Frequency of reporting	Quarterly
Data entry	Q57= Total number of "Neutral" responses = _____ Q58= Total number of "satisfied" responses = _____ Q59= Total number of Patient Satisfaction surveys completed = _____ Q60= Total number of patient satisfaction criteria's evaluated] = _____

Section 4: Hospital Supportive Supervision Site Visits

Supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, optimizing the allocation of resources, promoting high standards, team work and better two-way communication (MARQUEZ & KEAN, 2002). Supportive supervision involves directing and supporting HSPs in order to enhance their skills, knowledge and abilities with the goal of improving health outcomes for the patients they manage. It is an ongoing relationship between HSPs and their supervisors.

4.1   Purpose of hospital supportive supervision site visits
   The purpose of a hospital supportive supervision site visit is:

- To provide guidance and technical assistance to improve hospital performance

- To assure the RHB that KPI and any other performance data reported by the hospital to the RHB is accurate

- To identify, recognize and learn from good practice, which can then be shared with other hospitals

- To identify areas for improvement

- To identify areas where additional support from the RHB or other partners is required, and to plan with the hospital for the provision of that support

These are common to all site visits conducted by the RHB but there may be additional reasons for site visits. The purpose of the site visit and specific areas of focus should always be agreed by the site visit team and should be informed to the hospital in advance of the visit taking place.

4.2 Overview of the supportive supervision site visit process

Step 1 Selection of the site visit team

Step 2 Pre-visit preparation

Step 3 the site visit

Step 4 Post-visit reports and follow up

Step 1: Selection of the site visit team
- RHB assigns site visit Team Leader
- Team Leader identifies additional team members

······► 6 weeks before site visit

Step 2: Pre-visit preparation
- Team Leader collates information about hospital performance
- Team Leader contacts hospital to request additional information and gives dates of site visit
- Team leader prepares draft Site Visit Briefing Document and sends to team members

······► 4 weeks before site visit

- Site visit team reviews and finalizes Site Visit Briefing Document
- Agree roles and responsibilities for the duration of site visit

······► 2 weeks before site visit

- Site visit briefing document and agenda sent to hospital CEO
- Dates of site visit meeting confirmed

······► 1 week before site visit

Step 3: Conducting the site visit
- Opening meeting with CEO and SMT
- Evidence gathering
- Site visit team collates information and agrees findings
- Closing meeting with SMT prior to departure

Step 4: Post Visit Follow up
- Site Visit Report prepared and sent to hospital CEO

······► 1 week after site visit

- Hospital sends Hospital Response & Action Plan to RHB

······► 3 weeks after site visit

- Site Visit Report & Hospital Response & Action Plan are distributed to relevant stakeholders

······► 4 weeks after site visit

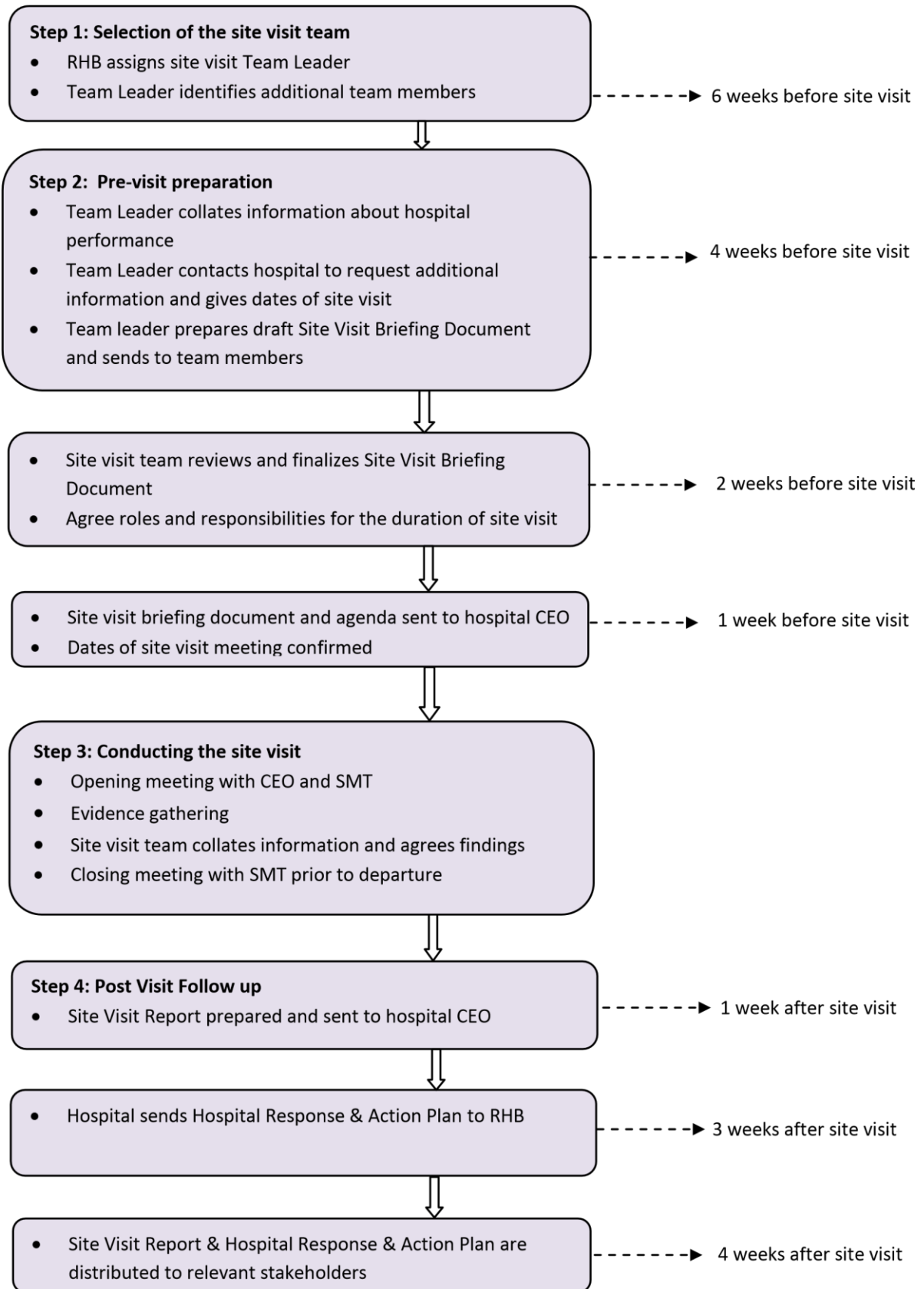Figure 1: Overview of the supportive supervision site visit process

4.3   Selection of the site visit team

The first step in the site visit process is to determine membership of the site visit team.

The site visit should be led and coordinated by the RHB in collaboration with other partners as relevant. Potential participants include FMOH staff, staff from other hospitals (e.g. a respected hospital CEO), partners and others.

A minimum of three individuals should conduct the site visit. This will allow each person to carry out specific functions during the site visit and minimize the time required at the hospital.

A team leader should be assigned by the RHB to oversee the site visit process. The roles of the team leader include:

- To establish membership of the site visit team

- To prepare the site visit briefing document

- To co-ordinate the site visit process, following the steps outlined below

- To ensure communication between site visit team members both before and after the site visit is conducted

- To communicate with the hospital CEO both before and after the site visit

- To prepare the site visit report and distribute to relevant stakeholders (e.g. RHB Head, Hospital CEO and GB Chair, site visit team members).

- To ensure the hospital provides a written response to the site visit report. To follow up on any action described in the site visit report or the hospital response

- To ensure the site visit report and the hospital response are maintained on file by the RHB

- To establish the date or timeline within which the next hospital site visit should be conducted

4.4 Pre-visit preparation for a site visit

The success of a site visit is dependent on adequate planning and preparation by both the site visit team and hospital management.

4.4.1 Preparation by the site visit team

Collate information

Firstly, the site visit team leader should collate all available evidence about the performance of the hospital, in order to identify specific areas that should be addressed during the site visit. Much of this evidence will already be on record with the RHB. As a minimum, the following information should be reviewed:

- The most recent site visit report and the hospital response & action plant

- The most recent and previous hospital KPI reports

- The most recent and previous hospital self-assessment reports on attainment of EHSTG standards

The hospital KPIs and attainment of EHSTG standard reports should also be compared with other hospitals in the region to assess how well the hospital is performing in relation to others.

If any of the above information is not available in the RHB, the team leader should contact the hospital CEO to request them to submit the missing information.

Prepare draft site visit briefing document

After gathering the above information, the site visit team leader should review all evidence and based on this should prepare a site visit briefing document. This should include:

- Summary of hospital performance

- Strengths/successes of the hospital

- Areas of possible weakness

- Evidence that requires validation (e.g. selected KPIs, selected chapters of EHSTG self-assessments etc)

- Priority areas for further investigation during the site visit

- Service areas to be visited during site visit

- Staff members to be interviewed during site visit

- Additional information for the hospital to prepare for the site visit team. For example, if the patient satisfaction rating score is low, the team leader may ask the hospital CEO to prepare the full results of the patient survey for review at the site visit. If the physician attrition rate is high the team leader may ask the CEO to provide a breakdown of the number and type of physicians who have left during the reporting period.

Consultation and finalization of site visit briefing document

The team leader should send the draft site visit briefing document together with all the above evidence (KPI reports, previous site visit report etc) to all site visit team members. Each team member should review and give comments.
All team members should then meet in person, or communicate by telephone or email, to agree the areas to be addressed during the site visit.

The team leader should then assign specific tasks and responsibilities to each team member and should prepare a schedule for the site visit which describes in detail the role of individual team members. A sample site visit schedule is presented in Figure 11, below.

Table 3: Sample Site Visit Schedule

Time	Activity	Site visit team members involved	Department &/or hospital staff involved
8.30am – 9.30am	Opening meeting	All	CEO Senior management team
9.30am – 3.00pm	Information Gathering by visits to departments and service areas	*Insert name of first team member*	*Insert name of departments/service areas to be visited and staff members to be interviewed (eg OPD Case Team Leader) by first site visit team member*
		Insert name of second team member	*Insert name of departments/service areas to be visited and staff members to be interviewed (eg OPD Case Team Leader) by second site visit team member*
		Insert name of third team member	*Insert name of departments/service areas to be visited and staff members to be interviewed (eg OPD Case Team Leader) by third site visit team member*
3.00pm – 4.00pm	Collation of information gathered	All	n/a
4.00pm to 5.00pm	Closing meeting	All	CEO Senior management team

Inform hospital CEO of date and purpose of site visit

After finalization of the site visit briefing document and schedule the team leader should contact the hospital CEO to confirm the dates of the site visit. The site visit briefing document and schedule should be sent to the CEO so that he/she can ensure that the required hospital staff are available on the days of the site visit, and can prepare the additional evidence requested by the site visit team

4.4.2 Preparation by the Hospital

After receiving the site visit briefing document and schedule, the hospital CEO should share these with the senior management team and should prepare any supplementary evidence requested in the briefing document.

The CEO should inform all hospital staff that a site visit is being conducted; giving a general overview of the purpose of the site visit and priority areas that the site visit team will review. In particular, the CEO should ensure that the management and staff of all service areas that will be visited during the site visit are available on the days of the site visit.

4.5   Conducting the site visit

The site visit should last between one to two days, although may be lengthened if necessary.

4.5.1 Opening meeting

On arrival at the hospital, the site visit team should first have an opening meeting with the CEO and SMT to give an overview of the purpose of the site visit, to confirm the schedule and to receive any additional information that had been requested from the hospital. The SMT should also be given opportunity to comment on the schedule and to add any areas that they think are missing and that they would like the site visit team to review. The site visit team may also take this opportunity to update the SMT on any relevant regional or national developments that the hospital should be aware of.

4.5.2 Information gathering

The team should then split up, each team member visiting the departments and services within the hospital as per the planned schedule.

Each team member should prepare detailed notes on their activities during the site visit, ensuring that the specific questions raised in the site visit briefing document are addressed.

4.5.3 Collation of evidence

After visiting the different service areas, the site visit team should meet together and should report back to on their assigned tasks. Together, the team should agree initial findings of the visit, including strengths and weaknesses of the hospital, recommendations to the hospital and specific areas that the hospital should address.

The team should also identify areas where additional support from the RHB is required and a provisional date/timeline for the next site visit.

4.5.4 Closing meeting

After the internal meeting among site visit team members alone, the team should then invite the hospital CEO and SMT to join them for a closing meeting. The team should present their overall findings as described above, and give opportunity to the SMT to respond to these. These findings should be seen as provisional, with the possibility of adding further areas or revising the focus after further reflection.

4.6   Post Visit Follow Up

Following the site visit, the team leader should prepare a detailed report that describes how the visit was conducted and the main findings and recommendations arising.

The report should be reviewed by all site visit team members. When reviewing the draft report team members should consider:

- Does the report present the impression of the hospital that you want it to convey?

- Does the report contain the key messages arising from the site visit?

- Does the report describe any follow up action that is expected from the hospital?

- Are recommendations based on evidence gathered during the site visit?

- Are all recommendations important? Are they feasible?

- Does the report identify any follow up action or support that is required from the RHB?

- Will the report help to improve hospital services? If not, how can the report be improved?

After finalizing the report by the site visit team, the report should be sent to the hospital CEO who should review and prepare a hospital response & action plan that describes specific actions that the hospital will take in the light of the report. When reviewing the report the hospital CEO should consider:

- Is the report factually accurate? If not, the CEO should include a correction of any errors in their written response

- What specific actions should the hospital take to address the recommendations made in the report? In what time frame?

- Does the report describe all areas of support that the hospital expects from the RHB to assist the hospital to act on the recommendations?

- Are there any additional comments that the CEO would like to raise with the RHB about the site visit process itself? Anything that could be improved in the process?

The CEO should send a copy of the hospital response and action plan to the site visit team leader.

After finalizing the site visit report and the hospital response, copies of both should be shared with the RHB Head and all relevant stakeholders. Copies should be kept on file within the RHB and used as evidence when preparing subsequent site visits and regional review meetings.

Section 5: Regional Review Meetings

5.1   Purpose

Regular meetings between the RHB and all hospitals in the region provide the opportunity for communication and experience sharing between the RHB and hospitals. Specifically review meetings can be used to:

- Present and discuss hospital performance reports
- Benchmark
- Identify and reward good practice
- Share successes and challenges discuss
- other relevant topics

5.2   Frequency of meetings

Review meetings should be held as a minimum every six months.

5.3   Length of meeting

In general the meeting should last for two days, but may be longer if the need arises.

5.4   Participants

    a)   RHB staff

The meeting should be attended by RHB curative and rehabilitative core process team members. The RHB Head and deputies should also attend whenever possible. Additional RHB staff members should be invited if the agenda includes topics that are of relevance to them.

    b)   Hospital staff

As a minimum the hospital CEO and Medical Director should attend the meeting. Additional participants could include other members of the hospital senior management team and/or the Governing Board Chair.

    c)   Health Services Quality Directorate

The FMOH regional focal persons for the region should be invited to attend since this will maintain strong communication between FMOH, the RHB and hospitals and will build capacity in FMOH to support the RHB and hospitals when required.

    d)   Other

Additional partners could be invited to attend according to their area of expertise and relevance for the agenda.

5.5   Pre -Meeting Preparation

Before each meeting the RHB should determine the venue, set the meeting agenda, identify participants and send an invitation letter plus agenda to all hospitals, describing which participants should attend to represent the hospital. Additional partners such as FMOH staff or NGO partners should be invited as relevant. The invitation letter and agenda should be sent at least 3 weeks in advance of the meeting, with a follow up email or phone call to confirm attendance approximately one week in advance of the meeting.

To prepare for each meeting, the RHB should review all hospital KPI reports and the most recent site visit report and hospital response and action plan. Using these reports the RHB should identify successes and challenges within individual hospitals or across the region as a whole.

Based on the findings, the RHB should identify specific hospitals to give presentations or share experience at the meeting and should inform these hospitals in advance so that the hospitals can prepare all necessary information.

5.6   Conducting the meeting

The meeting should be chaired by the RHB, with additional facilitators for each session or topic according to need.

Specific individuals from within the RHB, FMOH or partners should be assigned to take minutes of the meeting.

At each meeting the RHB should give a presentation on the KPI and EHSTG standards assessment reports from each hospital, including regional averages and recommendations from the RHB in response to the findings. Other agenda items will vary from meeting to meeting according to need.

5.7   Post meeting follow up

The RHB should prepare minutes and circulate these to all participants within a maximum of two weeks following the meeting. The minutes may also be sent to others as relevant (for example the RHB Head and FMOH/HSQD).

Section 6: FMOH and RHB Meetings

6.1 Purpose

Regular meetings between FMOH and all RHBs provide the opportunity for communication and experience sharing between regions. Specifically FMOH/RHB meetings can be used to:

- Present and discuss regional performance reports
- Benchmark
- Identify and reward good practice
- Share successes and challenges
- Share recent research reports related to hospital
- Performance discuss other relevant topics

6.2 Frequency of meetings

FMOH/RHB meetings should be held biannually.

6.3 Length of meeting

In general the meeting will last for three days, but may be longer if the need arises.

6.4 Participants

    a)   FMOH Staff

All members of the FMOH should attend the meeting. Additional FMOH staff should be invited if the agenda includes topics that are of relevance to them.

    b)   RHB Staff

Ideally, all members of each CRCPT of all RHBs should attend every meeting, but as a minimum the RHB core process owner and hospital lead should be in attendance.

    c)   Hospital staff

A selected number of hospital CEOs, governing board chairs and/or other senior managers should be invited to attend meetings depending on the agenda items.

    d)   Other

Additional partners could be invited to attend according to their area of expertise and relevance for the agenda.

6.5   Pre- Meeting Preparation

Before each meeting FMOH should determine the venue, set the meeting agenda, identify participants and send an invitation letter plus agenda to all RHBs +/- specific hospitals +/- other partners as relevant. The invitation letter and agenda should be sent at least 2 weeks in advance of the meeting, with a follow up email or phone call to confirm attendance approximately one week in advance of the meeting.

To prepare for each meeting, FMOH should review all regional KPI reports to identify successes and challenges within individual regions or across the country as a whole.

Based on the findings, FMOH should identify specific RHBs to give presentations or share experience at the meeting and should inform these RHBs in advance so that the RHB can prepare all necessary information.

6.6   Conducting the meeting

The meeting should be chaired by FMOH, with additional facilitators for each session or topic according to need.

Specific individuals from within FMOH or partners should be assigned to take minutes of the meeting.

At each meeting FMOH should give a presentation on the KPI and EHSTG standards assessment reports from each region, and recommendations from FMOH in response to the findings. Other agenda items will vary from meeting to meeting.

6.7   Post meeting activities

FMOH should prepare minutes and circulate these to all participants within a maximum of two weeks following the meeting. The minutes may also be sent to others as relevant (for example all RHB heads, and other FMOH directors or Ministers).

7. Glossary

Abdominal route	Through a surgical incision in the belly
Abdominal surgical delivery	Removal of the fetus, placenta etc. through a surgical incision in the belly
Admission	Going into hospital
Anesthesia	Method of putting patient to sleep or stopping feeling in a part of the body for surgery
Ante partum	Pregnancy before delivery of a baby
Assisted delivery	Birth of a baby in which the midwife or surgeon manipulates the baby as it moves through the birth canal
Caesarian section	Operation to deliver a baby through an incision in the uterus
Cartilage	Tissue between bones
Case team	A team within the hospital i.e. for in patients
Craniotomy	Procedure to remove part of skull
Day surgery unit	Department in the hospital where patients are operated on then go home the same day
Delivering mother	Woman in the process of delivering a baby
Dental	Concerning teeth
Discharge	Leaving hospital
Eclampsia	Seizures/fitting - potentially fatal disorder of pregnancy
Elective	Planned ahead, not emergency
Emergency attendance	Occasion when a patient goes to the emergency room for treatment
Emergency room	Department in the hospital where emergency patients are treated
Family planning	Service to advise on controlling fertility so pregnancy is planned
Fetus	Baby in the uterus

Forceps delivery	Delivery of a baby using forceps to pull the baby out
Gestational age	Age of the baby in the womb during pregnancy, i.e. how far on in pregnancy
Gynecology	Medical specialty concerned with areas of women's health such as fertility, pregnancy, continence
Hemorrhage	Bleeding
Hospital performance monitoring framework	Ethiopian system for monitoring the performance of health facilities
In patient	Patient staying in the hospital
Incision	Cut in the skin by a surgeon
Infection prevention processes	Procedures like regular hand washing and sterilization of instruments which stop the spread of infections
Instrumental delivery	See assisted delivery
Intensive care unit	Department in the hospital for acutely ill patients with higher levels of medical and nursing care
Intra partum	During delivery of a baby
Key performance indicator	An agreed measure that all facilities collect in the same way
Laboring mother	Woman in labor
Live birth	Baby who is born alive
Maternity	Concerning pregnancy and childbirth
Medical record	Papers that document the care and treatment a patient received
Morbidity	Illness or disability
Mortality	Death
Neonatal	Concerning newborn babies
Ophthalmology	Medical specialty for eye diseases
Out patient	Patient visiting the hospital for treatment

Performance improvement	Process to improve the organization's performance
Postpartum	A description of the mother after delivery of a baby
Pressure ulcer	Skin breakdown because of continued pressure
Private wing	Part of the hospital where patients pay for all services they receive
Psychiatry	Medical specialty for mental health
Purulent	With pus, infected
Referral	Recommendation that a patient attend another hospital or clinic
Sacrum	Bottom of the back above the buttocks
Stillbirth	Baby who is born dead
Subcutaneous tissue	Tissue under the skin
Supportive supervision site visit	A visit by the RHB and partners to the hospital to review performance
Surgical delivery	Baby delivered by an operation
Surgical site infection	Infection at the place on the body where a surgical incision was made
Triage	A process of sorting patients into priority groups for treatment according to need
Uterus	Womb
Vacuum delivery	Delivery of a baby using a suction instrument to pull the baby out
Vaginal delivery	Baby delivered normally
Well baby clinic	Clinic to checks on babies' development
Wound	Area of damaged skin for example from an injury or surgery
Wound dehiscence	An area of a wound which is not healing and has come apart or broken down

8. Appendices
Appendix1: HOSPITAL CASH AUDIT TOOL

Clean and safe health care facility(CASH) Audit Tool		
Hospital General Information		
Date of Assessment		
Hospital Name		
Region, Zone/Sub city, District/ woreda		
CEO	Name	
	phone no	
	Email	
CASH focal person	Name	
	phone no	
	Email	
Number of Staff(Total)		
Number of Environmental health officers		
Number of Staff(Cleaners)		
Number of Staff(Laundry staffs)		
Name of Assessors		

1. CASH Structure and management

	Standard	Verification Criteria	Score			Remark
			***	**	*	
	Management, commitment, support and coordination	☐ Governing board support & monitor CASH/IPPS activities ☐ SMT establish a system to support and monitor CASH/IPPS activities ☐ SMT ensure adequate resource allocation (human & budget for material & supplies) ☐ Department performance assessment and mechanism of recognition in place				
	Functional /Active CASH/IPPS coordinating committee	☐ Updated TOR for the committee ☐ Availability of annual CASH specific operational plan at focal point, committee and SMT ☐ Conduct regular meeting at least quarterly and minutes should be documented ☐ Conduct progressive assessment quarterly &report should be sent to SMT ☐ All hospital health professionals, laundry staffs, kitchen staffs and housekeeping staffs should be trained on CASH/IPPS ☐ Conduct Hospital wide Campion at least quarterly				

			Score			
		with focusing changing the attitude of people				
	The hospital has a strategy to improve the implementation of CASH.	☐ Involvement of all departments/units ☐ Involvement of patients ☐ Involvement of communities ☐ Involvement of senior physicians				

2. Facility Management

No	Standard	Verification criteria	Score			Remark
			***	**	*	
4	Protective Surrounding fence	☐ Fence which surrounds all the hospital ground which will not allow the entrance of pets and other animals with a functional gate ☐ Safe especially for psychiatric and pediatric patients ☐ At least with two gates that could aid in case of emergencies.				
5	External ground appearance and tidiness	☐ Hospital external ground (at least 5m-20m from the fence) is free from any hospital & community generated waste ☐				
6	The hospital should have good Internal compound appearance and tidiness	☐ Tidy and well maintained internal ground ☐ Free abandoned medical equipment/ old cars, etc ☐ Designated social green areas/parks with seating facilities ☐ Clinical and General waste				

		☐ containers placed only in recommended places ☐ Clearly marked, well lit, and safe walk ways including from parking area ☐ Electrical wires are secured and safely fixed within the compound				
7	The hospital has an appropriate Signage so as to make accessible for clients/patients	☐ Easily visible Hospital sign directing people from around (approximately 3- 5 meters from floor level, framed, legible text and visible at day and night) ☐ Clear signage in the hospital showing the name of the hospital wards, departments, clinics, hazards, etc ☐ Signs on doors, toilets, etc described/written either in pictures, words or both and consistent in appearance ☐ Signs for toilets are visible from all patient areas				
8	The hospital has a Clean and tidy Hospital buildings& immediate surrounding	☐ Clean, tidy, and free from cracks Hospital buildings ☐ Drainage system within and around hospital building(s) e.g. gutters, pipes, etc, should be free from any obstructions, e.g. vegetation ☐ Doors, windows, and window frames are clean, not damaged, properly fixed, and painted				
9	The hospital should have clean and safe Hospital building corridors and waiting area	☐ Visibly clean, free from any obstacles, well lit and suitable for any whether condition ☐ Stairs, steps and lifts, internal and external, including all component parts, are visibly clean and well-maintained ☐ Waiting area with adequate space, clean & not				

		damaged chairs, and health education program				
10	The hospital ensures good Traffic flow management	☐ Defined and posted time (schedule) for visitors ☐ Restrict only authorized persons at those high risk areas				
11	The hospital has a regular supply safe Electric supply	☐ Continuous electricity availability (24/7) in the hospital with backup source ☐ All electric lines, switches, sockets, and ventilation grills are properly, insulated, and safe				
12	The hospital has a Fire safety plan	☐ The Hospital has Fire safety plan ☐ Fire Emergency drill conducted at least annually ☐ Contact address in case of fire emergency posted on working areas ☐ Staff trained on fire safety ☐ Functional fire extinguishers (expire date is up to date) placed at easily recognizable place. ☐ Functional & annually inspected water hose				
13	The hospital practices Housekeeping works	☐ There are adequate number of cleaners per the standard ☐ There is adequate cleaning supplies ☐ Cleaning work plan developed and implemented ☐ Established system for monitoring cleaning activity				
14	The hospital has Pest & rodent control system	☐ Established system/mechanism for pest and rodent control (outsourced or trained and assigned personnel) ☐ Regular pest & rodent control/inspection every 3 month				

15	The hospital has Noise pollution control system	☐ Free from internal sound disturbance (e.g. sounds from generator, constructions, workshop, etc) ☐ No noise pollution sign should be posted inside the compound				
16	The hospital has adequate Ventilation and Illumination	☐ All rooms/service areas have adequate natural or artificial light access ☐ All service areas/rooms are well ventilated with natural or artificial system				

Water, Sanitation, and Hygiene

No	Standard	Verification criteria	Score			Remark
			***	**	*	
17	The hospital ensures availability of adequate water supply	☐ Improved water supply piped into the facility or in premises ☐ Water available at all times (24 hrs/day7 days a week) and of sufficient quantity for all service areas. ☐ A reliable **drinking water** station is present and accessible for staffs, patients and care givers at all times and all locations/wards.				
18	The hospital has appropriate Storage/Reservoir to ensure continuous water supply	☐ Water storage is sufficient to meet the needs of the facility for 2 days ☐ Drinking water is safely stored in a clean bucket/ tank with cover and tap ☐ Reservoirs are made from rust resistant material ☐ Cleaning of Reservoirs conducted on regular base twice a year (at least every six month) ☐ Reservoirs placed at least 50 cm above the ground and are protected with				

No	Element	Standard	Score			Remark
			surrounding fence.			
19	The hospital should have Water safety plan	☐ Hospital have a water safety plan ☐ All water pipelines are installed underground and free from leakage ☐ Water is tested regularly four times a year through collecting a representative sample ☐ Drinking water has appropriate chlorine residual (0.2mg/l or 0.5mg/l in emergencies)				
20	The hospital should have adequate Showers	☐ A separate male and female based shower for in-patient wards (one shower per 40 patient)with continuous water availability and light ☐ A separate male and female staff shower ☐ Free from any solid and liquid waste ☐ Visibly clean wall-attached shower chairs (free from blood and body substances, scum, dust, lime scale, stains, deposit or smears.) ☐ Showers have a door with lock. If there is no door, privacy curtains should be installed				

Sanitation and Waste Management

No	Element	Standard	Score			Remark
			***	**	*	
21	The hospital should have adequate rest room	☐ Availability of proportional toilet to patient ratio (one toilet to 20-24 patients) ☐ Separated for male and female				

			patients/clients ☐ Separated for patient and staff ☐ Visibly clean from any solid and liquid waste ☐ Free form bad odor ☐ Ensure privacy with functional door and lock. ☐ Adequate functional artificial light for the night time. ☐ At least one toilet meets for menstrual hygiene management (tap water inside the room etc) ☐ Toilets at maternal waiting area/maternity ward are suitable for pregnant mothers ☐ At least one toilet meets the needs of people with reduced mobility. ☐ Functional hand hygiene stations (running tap water, soap, dust bin, etc) within 3 m from latrines. ☐ Functional waste bin				
22	The hospital should practices Proper solid Waste management system	☐ Health care waste management manual/SOP available in clinical areas ☐ Functional waste collection containers for 1) non - infectious (general) waste, 2) infectious waste and 3) sharps waste in close proximity at necessary service				

		point. ☐ Waste correctly segregated at all waste generation points. ☐ Separate functional waste transport equipment for clinical, domestic and in the case of Mercury & other toxic materials ☐ Domestic waste pit(for burning of non-infectious waste) and burial pit(for the burial of non-combustive waste) free from odor/offensive smell ☐ Dedicated ash pits available for disposal of incineration ash ☐ Fenced and protected waste storage and disposal site (burial pit, incinerator, placental pit, etc) ☐ Separated storage area for Hazardous and non-hazardous waste before treatment/disposal of or moved off site. ☐ Appropriate personal protective equipment for all staff in charge of waste transportation, treatment and disposal. .					
23	The hospital should have an appropriate	☐ Functional and well-designed incinerator (type) ☐ A trained person is					

	and functional Incinerator	responsible operating incinerators ☐ Sufficient energy/temperature supply for incinerator for complete combustion				
24	The hospital should have an appropriate and functional placental pit (Where applicable)	☐ Clean and functional placental pit without unpleasant or distasteful odor ☐ Anatomical-pathological waste is put in a dedicated pathological waste/placenta pit, burnt in a crematory or buried in a cemetery				
25	The hospital should practices Proper Waste management system	☐ Proper liquid waste management system with sewerage line connected to a municipal or own septic tank. ☐ Functional liquid waste treatment system before discharging from the facility ☐ Sewerage lines connected from liquid waste generation points source are free from any leakage ☐ Separate sewerage line & septic tank for pathogenic/chemical waste and general/non infectious connected				

Hygiene

No	Element	Standard	Score			Remark
			***	**	*	
26	The hospital has Proper hand hygiene stations	☐ Functioning hand hygiene stations (running tap water, soap, alcohol hand rub, etc) are available at all points of care/service area and waste disposal site ☐ Visibly clean sink and wall-attached dispensers/soaps ☐ Hand hygiene promotion materials clearly visible and understandable at key places. ☐ Hand hygiene compliance activities are undertaken regularly.				
27	The hospital ensures hygiene and cleanliness of all rooms	☐ Visibly clean, shine, washable & uniform physical appearance floor with no cracks and holes ☐ Visibly clean & washable wall surface and ceiling including skirting with no cracks and holes ☐ All furniture's (chairs, tables, commodes/lockers, curtains/screens, mirrors, and notice board) are visibly clean and not damaged ☐ All parts of the bed (including				

		mattress, bedsheets/linen, bed frame, wheels, castors, patient pajamas, and bed nets) are visibly clean and not damaged ☐ All medical equipments (weighing scales, drip stand, oxygen cylinder, autoclaves, baby incubator, etc) are visibly clean and non functional stored away from the room ☐ The waste receptacle are visibly clean and covered ☐ Beds for patients separated by a distance of 1 meter from each other edge.					
28	The hospital should ensure Food hygiene practices	☐ Developed, posted and practiced SOP at least for Dish washing & Food Safety ☐ Separate kitchen room and store are ☐ Kitchen room& store visibly clean, well ventilated, odor free, well lit and free from rodents ☐ Food preparation & serving equipments are visibly clean, not damaged, not stained, and free from rust ☐ Food					

		transportation carts are made from aluminum with functional door				
		☐ Dishwashers are three compartment with detergent, and running hot and cold water				
		☐ Cutting boards are made from plastic (propylene plastic)				
		☐ All food handlers have regular medical checkup every three month				
		☐ The Hospital provides food hygiene training twice a year for all food handlers				
		☐ All food handlers wear the recommended PPE while on job and apply personal hygiene practice				
		☐ Fridges and freezers are available separated with food type				
		☐ All fridges and freezers are visibly clean, temperature monitored, and with functional gage				
		☐ The Hospital establish functional food safety monitoring team				

29	The hospital should ensure personal hygiene and appearances of staff	☐ Staff dresses clean uniforms with name and job title identification ☐ All staff wears proper PPE on task specified ☐ Staff uniforms are not allowed in staff canteens/restaurant				
30	The hospital ensures the availability of Laundry/Linen processing/ service	☐ Prepared, posted, and applied SOPs for linen processing. ☐ Designated area for sorting soiled and non soiled linen ☐ At least two separately designated sink system for soaking soiled linen ☐ Adequate laundry machines for washing, twisting, drying, and ironing. ☐ Sufficient and separate trolleys for transporting clean/washed, soiled, and non-soiled linens. ☐ Two separate door system for receiving soiled and exit of cleaned linen ☐ Separated room for cleaned linen with clean and not damaged shelves ☐ Designated, adequate, clean, and protected				

		place for natural air drying that can serve in any weather condition				
31	Instrument processing	☐ Prepared and posted SOPs and job aids for instrument processing. ☐ Staffs properly follow the recommended steps of instrument processing soon after the procedure (i.e. decontamination, cleaning, sterilization and storage). ☐ Adequate and functional instrument processing machines are provided ☐ Clean and protected shelves for processed/sterilized instruments ☐ Instrument processing machines are calibrated (preventive maintenance) annually ☐ Instrument processing equipments (buckets, tooth brush, etc) are clean and not damaged				

Appendix 2: Outpatient Waiting Time to Treatment

Purpose of survey:

The average OPD wait time is one of the Key Performance Indicators that should be reported by hospitals to their Governing Board and to the RHB has a measure of hospital performance. **Period of survey:**

The survey should be conducted on Monday and Thursday of the first week of the last month of each quarter.

Role of KPI Owner:

The hospital should assign an „owner" for the KPI „Outpatient Waiting Time to consultation". He/she is responsible to oversee the survey , to select and train surveyors, to issue „Waiting Time Cards" to each surveyor, to receive completed „Waiting Time Cards" from the surveyors at the end of the survey period, and to calculate the average wait time at the end of the survey period.

Additionally, at the start of each survey period the KPI Owner should inform all OPD staff that the survey is taking place and should instruct OPD Case Teams to complete the relevant section on the „Waiting Time Card" for every patient seen and ensure that all Waiting Time Cards are returned to the surveyor at the end of the survey day.

Selection and role of surveyors:

The KPI Owner should assign individuals to act as surveyors. The number of surveyors required will depend on the patient load. However, there should be sufficient surveyors to ensure that the waiting time of at least100 outpatient is measured during the survey. In those facilities where the outpatient load is very high (>200), every *3rd* patient may be taken to a total of at least 100 patients. As an approximation, the number of surveyors required will be approximately the same as the number of individuals conducting patient registration.

Ideally, the surveyors should be individuals who DO NOT WORK regularly in the outpatient department in order to avoid bias. Surveyors could be volunteers from the community, students or hospital staff assigned from other departments. If necessary, the hospital should provide payment to surveyors according to the number of hours worked.

The surveyors should follow the methodology outlined below to conduct the survey and should submit all completed „Waiting Time Cards" to the KPI Owner at the end of the survey period.

Role of OPD Case Teams:

A member of each clinical case team should receive the Waiting Time Card from each and every patient seen during the survey period. He/she should record on the Card the time at which the clinical consultation begins, and the name of the case team. Instructions should be

given to each case team to provide all completed cards to the surveyor at the end of the survey day. Case teams should ensure that no Waiting Time Cards are lost or misplaced.

Methodology of Survey:

a) **Assign surveyors to the areas where patients arrive at the outpatient department as follows:**

- If outpatients undergo registration before triage → assign surveyors to patient registration area

- If outpatients undergo triage before registration → assign surveyors to triage area

- If the hospital has an appointment system and patients go immediately to the OPD waiting area (without passing through registration or triage) → assign surveyors to OPD waiting areas

b) **Issue „Waiting Time Card"**

Each surveyor should have a batch of „Waiting Time Cards" as below:

OPD Waiting Time Card	**Card Number:** _____

Patient name: _____ ___ (completed by surveyor)

Time of patient arrival: _____ (completed by surveyor)

Time clinical consultation begins: _____ (completed by clinical case team member)

Name of case team: _____ (completed by clinical case team

OPD Waiting Time Card	**Card Number:** _____

ታካሚው ስም: _____ ___ (ትሪያዠክ ፍሉ ይሞላል)

ታካሚው የደረሰበት ጊዜ: _____ (ትሪያዠክ ፍሉ ይሞላል)

የህክምና አገልግሎት የ ጀምረበት ጊዜ): _____ (የኬስ ቲም አባል

(የተመላላሽተካሚህክምናለማግኘትየወሰደበትጊዜ(በደቂቃ): _____ (የመረጃ

Before any of the Waiting Time Cards are given out, Card Numbers should be written on every card to that they can be easily tracked by the surveyor and the clinical case teams. As soon as a patient arrives at OPD the surveyor should enter the patient's name and time of arrival on a Waiting Time Card and then hand the Card to the patient. The surveyor should instruct the patient to give the card to a member of the clinical case team.

The Surveyor should keep track of the number of cards issued and the number of cards completed. To do this he/sh e should keep a tally of the number of Waiting Time Cards issued and follow up any that are missing at the end of the day.

c) Clinical Case Teams receive „Waiting Time Card‟

On arrival in the consultation room, the patient should hand over the Waiting Time Card to a member of the case team. If the patient does not automatically hand this over then a member of the team should request the Card from the patient.

The case team member should record on the Card the time at which the consultation begins. The case team should keep all Cards received from patients.

d)   Surveyor collects completed „Waiting Time Cards‟.

At the end of the day (or close of clinic) the surveyor(s) should collect all Cards from each and every Case Team and should compare this with the list of Cards issued. If any cards are missing the surveyor(s) should follow up with the relevant Case Team and determine whether the patient was seen that day.

e)   Every effort should be made to ensure that no Cards are missing or lost because this could lead to an inaccurate survey result. **Surveyor calculates waiting time for each patient**

After receiving the Waiting Time Cards from each clinical case team, the surveyor should calculate the wait time for that patient (in minutes) and should enter it onto the Card.

f) KPI Owner calculates average waiting time

A t the end of the survey period the KPI owner should collect all Waiting Time Cards from each surveyor.

The KPI Owner should tally the total wait times and divide by the total number of completed Cards in order to calculate the average wait time during the survey period. In cases where the patient was seen on the same day but the Waiting Time Cards were lost or incomplete, the Waiting Time Cards should be excluded from the survey count.

g) KPI Owner reports to KPI focal person

After calculating Outpatient Waiting Time the KPI owner should report all data elements and KPI result to the KPI focal person. The KPI focal person will then check the calculations and enter them into the KPI report form.

h) Optional, supplementary data analysis

If the average wait time is very long (especially if some patients are not seen on the same day) then the surveyor may also want to record the range (shortest and longest) of wait times.

Similarly, the waiting time for each clinical case team could be analyzed separately to see if there are any differences between clinical teams. This information could help to assess the efficiency of each case team and/or to determine the need for additional clinical staff in particular case teams and/or the need for patient numbers assigned to a specific case team to be decreased or increased.

Appendix 3: Emergency Patients Triaged Within 5 Minutes of Arrival

Purpose of survey:

Through BPR, the Ministry of Health has set a stretch objective that „any patient with the need for emergency treatment should be provided with the service within 5 minutes of arrival at the hospital".

The proportion of emergency patients who undergo triage within 5 minutes is one of the Key Performance Indicators that should be reported by hospitals to their Governing Board and to the RHB has a measure of hospital performance.

Period of survey:

The survey should be conducted during the following time periods during the final week of the reporting period:

> Monday: 8am to 12 noon
>
> Wednesday: 12 noon to 5pm
>
> Saturday: 6pm to 8am

Role of KPI Owner:

The hospital should assign an „owner" for the KPI „% of patients triaged within 5 minutes of arrival in ER". He/she is responsible to oversee the survey, to select and train surveyors, and to calculate the proportion seen within 5 minutes at the end of the survey period.

Additionally, at the start of each survey period the KPI Owner should inform all ER staff that the survey is taking place.

Selection and role of surveyors:

The KPI Owner should assign individuals to act as surveyors. The number of surveyors required will depend on the patient load. However, there should be sufficient surveyors to ensure that the waiting time of each and every emergency patient is measured during the study period.

Ideally, the surveyors should be individuals who DO NOT WORK regularly in the emergency department in order to avoid bias. Surveyors could be clinical or non clinical staff from other hospital departments. If necessary, the hospital should provide payment to surveyors according to the number of hours worked.

The surveyors should follow the methodology outlined below to conduct the survey and should submit all completed „Triage Data Forms" to KPI Owner at the end of the survey period.

Methodology of Survey:

a) Assign surveyor(s)

One or more surveyors should be assigned to the ER Department for each study time period. The surveyor(s) should be located at the entrance to ER. If the hospital does not have a separate ER department the surveyors should be located in an area where they can identify easily identify emergency cases versus outpatient cases.

b) Surveyors complete „Triage Data Forms"

Each surveyor should have a batch of „Triage Data Forms" as below:

Sample Triage Data Form:

Patient number	Time of arrival	Time of triage	Wait time (minutes)	Wait time < 5 minutes? (Yes/No)
1	12.20	12.23	3	Yes
2	12.40	12.46	6	No
3	1.15	1.17	2	Yes
4	2.10	2.25	15	No
5				
6				
7				
8				

As soon as a patient arrives at ER the surveyor should enter the time of arrival on the Triage Data Form. The surveyor should follow the patient until the time of triage (ie until assessment by a clinical staff member). The surveyor should enter the time of triage on the Triage Data Form and calculate the wait time in minutes. The surveyor should then complete the final column on the Triage Data Form to state if the patient was triaged within 5 minutes of arrival (yes or no).

c) KPI Owner calculates % of patients triaged within 5 minutes (KPI 5)

At the end of the survey period the KPI Owner should collect all Triage Data Forms from each surveyor. The KPI owner should calculated the % of patients triaged within 5 minutes as follows:

Number of surveyed patients who undergo triage within 5 minutes of arrival in emergency room (Q9) ÷ Number of patients included in emergency room triage time survey (Q10) x 100

d) KPI Owner reports to KPI focal person

After calculating % of patients triaged within 5 minutes the KPI owner should report all data elements and KPI result to the KPI focal person. The KPI focal person will then check the calculations and enter them into the KPI report form.

Appendix 4: Completeness of Inpatient Medical Records

   Purpose of Audit:

The "% of medical records complete" is one of the Key Performance Indicators that the hospital should report <u>every quarter</u> to the Governing Board and Regional Health Bureau.

Frequency of Audit:

The audit should be conducted quarterly.

Role of KPI Owner:

The hospital should assign an „owner" for this KPI. He/she is responsible to oversee the Medical Record Audit, to select and train Medical Record staff who will conduct the audit, and to liaise with the Medical Records Department to select and obtain the Medical Records which are included in the audit.

Selection and Role of Medical Record Reviewers:

The Medical Record Reviewers should be members of the Medical Records Department. Each should review the assigned Medical Records following the checklist below and submit their completed Forms to the KPI Owner.

<u>**Methodology of Survey**</u>**:**

   a) **Select and obtain the medical records**

   Identify and list all patients who were discharged from an inpatient ward during the reporting period. This information can be obtained from the Medical Records Database or Admission/Discharge Registers.

   The sample size of medical records to be surveyed should be 50 or 5% (which ever number is higher) of the discharged patients. After identifying your sample size randomly select patients from the discharged list. Obtain the Medical Records of these patients from the Medical Records Department. If any Medical Record is missing, another patient /Medical Record should be selected as a replacement.

b) Complete Medical Record Review Form

For each of the selected Medical Records complete the following Review Form:

Medical Record Review Form

MR Number:
Date patient discharged from hospital:
Ward:

Inpatient Medical Record Checklist		
Section	**Yes**	**No**
1. Patient Card (Physician Notes): - Is this present? - Are all entries dated and signed?		
2. Progress note- documented at least once a day throughout the hospital stay?		
3. Order sheet: - Is this present and revised daily? - Are all entries dated and signed?		
4. Nursing Care Plan: - Is this present? - Revised daily, V/S taken at least QID for all admitted patient? - Are all entries dated and signed?		
5. Medication Administration Record - Is this present? - Are all entries dated and signed?		
6. Discharge summary - Is this present? - Are all entries dated and signed?		
7. clinical pharmacist record - Is this present? -Are all entries dated and signed?		
Total number of "Yes" and "No" Checks	_____	_____

MR Reviewed by:_____

Name of Reviewer: _____

Date of Review: _____

Appendix 5: New pressure ulcers reporting format

This form should be used to report new pressure ulcers arising in patients following admission to hospital.

Definition of Pressure Ulcer:

Pressure Ulcers arise in areas of unrelieved pressure (commonly sacrum, elbows, knees or ankles).

Either of the following criteria should be met:
- A superficial break in the skin (abrasion or blister) in an area of pressure *or*
- An ulcer that involves the full thickness of the skin and may even extend into the subcutaneous tissue, cartilage or bone

Ward (**ዋርድ**):
Name of patient:
Date of admission (**በሽተኛው የተኑበት ቀን**):
Reason for admission/diagnosis (**በሽተኛው የተኑበት ምክንያት**):
Date pressure ulcer detected (**ቁስል የተገኘበት ቀን**):
Clinical signs of pressure ulcer (**የአልጋ ቁስል ክሊኒካል ምልክቶች**):
Action taken (**የተወሰደው እርምጃ**):   Reported by : Name : _____ Position : _____
Outcome (to be completed at time of discharge) (**ውጤት (በሽተኛው ልወጣሲል**):   Signed :_____ Position : _____

Appendix 6: *Surgical Site Infection Report Form*

This form should be used to report infection occurring at the site of surgery in patients who undergo major surgical procedures (i.e. any procedure conducted under general, spinal or major regional anesthesia).

<u>Definition of Surgical Site Infection (SSI):</u>

<u>One or more </u>of the following criteria should be met:
- Purulent drainage from the incision wound
- Positive culture from a wound swab or aseptically aspirated fluid or tissue
- two of the following: wound pain or tenderness

    Localized swelling, redness or heat

- Spontaneous wound dehiscence or deliberate wound revision/opening by the surgeon in the presence of:
    o pyrexia > 38C or
    o localized pain or tenderness

An abscess or other evidence of infection involving the deep incision that is found by direct examination during re-operation, or by histopathological or radiological examination

Ward (**ዋርዶ**):	Date SSI detected :
Name of patient :	Date of surgery:
Type of surgical procedure :	
Name of surgeon :	
Clinical signs (**የተወሰየው እርምጃ**):	
Action taken (**የተወሰየው እርምጃ**):	
Reported by :	
Name :_____ Position : _____	

Outcome (to be completed at time of discharge) :

Signed : _____ Position:_____

Appendix 7: WHO Safe surgical check list

SURGICAL SAFETY CHECKLIST (FIRST EDITION)
World Health Organization

Before induction of anaesthesia ▶▶▶▶▶▶▶▶ **Before skin incision** ▶▶▶▶▶▶▶▶▶▶▶▶ **Before patient leaves operating room**

SIGN IN	TIME OUT	SIGN OUT
☐ PATIENT HAS CONFIRMED • IDENTITY • SITE • PROCEDURE • CONSENT	☐ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE	NURSE VERBALLY CONFIRMS WITH THE TEAM:
☐ SITE MARKED/NOT APPLICABLE	☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM • PATIENT • SITE • PROCEDURE	☐ THE NAME OF THE PROCEDURE RECORDED
☐ ANAESTHESIA SAFETY CHECK COMPLETED		☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
☐ PULSE OXIMETER ON PATIENT AND FUNCTIONING	**ANTICIPATED CRITICAL EVENTS**	☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
DOES PATIENT HAVE A: KNOWN ALLERGY? ☐ NO ☐ YES	☐ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?	☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
DIFFICULT AIRWAY/ASPIRATION RISK? ☐ NO ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE	☐ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?	☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT
RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)? ☐ NO ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED	☐ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?	
	HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES? ☐ YES ☐ NOT APPLICABLE	
	IS ESSENTIAL IMAGING DISPLAYED? ☐ YES ☐ NOT APPLICABLE	

THIS CHECKLIST IS NOT INTENDED TO BE COMPREHENSIVE. ADDITIONS AND MODIFICATIONS TO FIT LOCAL PRACTICE ARE ENCOURAGED.

Appendix 8: Patient Satisfaction

Survey Protocol: Patient Satisfaction

Purpose of Survey:

To provide a standardized survey for outpatients‟ and inpatients‟ experiences which hospitals can use to monitor patient satisfaction with services, and changes in satisfaction over time.

The Key Performance Indicator "Patient Satisfaction" will be calculated using the proportion of neutral and satisfied client responses among all clients surveyed in the specified period.

Period of Survey:

Hospitals should perform a total of 120 surveys each quarter (30 from each of the OPD, IPD, maternity and Emergency departments). The surveys should be collected over a time period of two weeks. No more than 3 surveys should be collected in a day and surveys should be collected on different days and different times of day (morning and afternoon; weekends, holidays and night duty shifts for OPD, IPD, maternity surveys).

All surveys should be administered at the time of discharge (if admitted) or at the end of the visit/stay right before the patient leaves the service area.

Role of KPI owner:

The hospital should assign an „owner‟ for the KPI „Patient Satisfaction‟. He/she is responsible to oversee the survey, to select and train surveyors, to issue surveys to each surveyor, to receive completed surveys from centralized collection area, calculate patient satisfaction (KPI 26) and response rate, and give all completed surveys to a data entry person who will enter them into the Access Database.

Selection and role of surveyors:

Each health facility should assign one or more individuals to administer the surveys to patients. The individual conducting the survey (also referred to as "surveyor") should understand the survey well, including all survey questions and answer choices. To minimize bias the surveyor should not be involved in direct patient care. A surveyor must have good interpersonal skills to interact sensitively with patients and must not lead the patients to particular responses but should administer the survey objectively. Each surveyor must be trained to ensure he/she understands the purpose and process of the surveys. Surveyors are responsible for collecting all completed surveys and returning them to a centralized collection area determined by the health facility.

Surveys can be completed by the patient themselves (written) or the surveyor may read each survey question to the patient and transcribe the patient response (oral). When orally administering the survey, the surveyor should read the question exactly as written on the survey tool. If the patient has a query about certain questions on the survey, surveyors should not provide responses or more detail about what the question might be. This will introduce the surveyor's interpretation into the question, which is a form of bias. When encountering such a challenge, the best approach is for the surveyor to remind the respondent that there is no right or wrong response and that the interpretation of the patient is the best possible one. Then, the surveyor should re-read the question for the patient.

Patient recruitment:

Participation is voluntary and patient anonymity must be maintained. No identifying information (such as patient's name) should be collected. All patients must be 18 years old or older. In addition, for admitted clients, participants must have a hospital stay of 2 days or more.

Participants should be excluded from both surveys if cognitively impaired and unable to understand the survey questions. For the outpatient survey, patients should be selected to reflect a diversity of outpatient areas. Emergency room services may also be assessed using the outpatient survey. For the inpatient survey patients should be selected from a range of different wards to reflect the diversity of services.

The surveyor should not select patients based on his/her presumptions about whether the patient appears pleased or not pleased with services rendered.

Methodology of Survey:

a) Assign and train surveyors

Selection and training of surveyors should be in accordance with above stated protocol and should be done well in advance of survey period.

b) Select patients for survey

Surveyors should be provided with a logbook to record the number of patients asked to participate in survey, number of surveys actually completed by patients and what type of survey was administered (written or oral). This is to measure the survey response rate as well as track surveys.

Patient recruitment should be in accordance with above stated protocol. Surveyor should then approach the patient to inquire if he/she is interested in completing a patient survey. The surveyor should explain the purpose of the survey and assure the patient of his or her anonymity. If the patient does want to participate they must then give their consent verbally before the survey can be administered.

c) Oral or written completion of survey

The survey may be completed by the patient themselves (written) or administered by the surveyor who will transcribe the patient's answers (orally). An ID number should be assigned to each survey sequentially as it is conducted. The ID should be entered on the survey form and in a logbook.

Written Survey:

Surveyors will provide a blank patient survey to the patient to be completed by him/her. Patient should complete the survey at the time it is distributed and be notified of a centralized collection area where they can return their completed survey.

The surveyor should record the Survey No. in logbook and identify it as a "written survey".

Oral Survey:

If the patient requests that the survey be conducted orally surveyors will read each question on the survey to the patient, transcribing the responses of the patient on to the survey form (tally their rating as per the service area). The surveyor should record the Survey No. in a logbook and identify it is as "oral survey". Once the survey is completed the surveyor should deliver it to a centralized collection area for the KPI data owner to collect.

d) KPI owner calculates Patient Satisfaction Indicator and response rate

At the end of the survey period the KPI owner should collect all completed surveys from the centralized collection area. The KPI owner should calculate Patient Satisfaction score by calculating the proportion of a clients responded by giving a neutral or satisfied score from the total number of clients participated in the survey.

The formula for the indicator is as follows:

[[Total number of "Neutral" responses + Total number of "satisfied" responses] / [total number of Patient Satisfaction surveys completed x total number of patient satisfaction criteria's evaluated]] x 100%

e) KPI Owner reports to KPI focal person and Data Entry Person

After calculating Patient Satisfaction the KPI owner should report all data elements and indicator to the KPI focal person. The KPI focal person will then check the calculations and enter them into the KPI report form.

Additionally, all surveys should be given to the appropriate data entry person to enter into the Access Database. See Appendix 8 for guidance.

Characteristics	Outpatient department			Emergency department			Inpatient department			Maternity department		
	D	**N**	**A**	**D**	**N**	**A**	**D**	**N**	**A**	**D**	**N**	**A**
D = Disagree N = Neutral A = Agree												
Had positive experience or felt respected during the first encounter with the hospital staffs (guards, receptionists, medical record room, triage)												
Hospital compound was clean, attractive and safe to patients, patient assistants, visitors and the hospital workers												
Easily identified the service areas where you want to get a service (reception service, runner, signage)												
Patient registration facilitated in a reasonable time												
Acceptable waiting time to get evaluated (seen by a doctor at OPD/1st												

THANK YOU FOR YOUR COOPERATION!

Date in Ethiopian calendar: date………………..…month……………..…year……………………………

Service area ……………………………………………….

evaluation by a HCW if admitted either in the IPD or labor ward)														
knows who provided their care, and what the role is of each provider on the care team (introduced during the encounter, ID badge)														
Able to identify who are doctors, nurses, and students														
Client called by name during encounters														
Privacy maintained at all times of care														
Expressed ideas during provider client interaction, actively listened without interruption														
HCP showed respect and tolerance at all encounters														
There was no incidence of physical or psychological abuse including insulting, shouting, withholding services														
Obtained consent before														

examination and procedures															
Provided with adequate time for counseling and informing about client's clinical condition (type and severity) and his/her treatment and care plan															
Information was clear and explained to their level of understanding															
Involved in treatment options and decision was made taking their say in to consideration															
Their wishes and decisions were respected even if the HCP disagrees															
Get excused for shortcomings															
All requested laboratory items were availed in the facility															
Get respected by laboratory workers															
Adequate information was provided regarding the process of test including sample collection methods and precautions, TAT, when, where and how to collect															

results etc													
Laboratory result was ready in a reasonable time (as per the counseling in the TAT)													
All prescribed drugs are availed in the facility													
Get respected by pharmacy workers													
Adequate time and information was given regarding the drug usage including frequency, dose, possible adverse events, storage, duration, what to do in case of doubts or adverse events like using DIS in the hospital													
Toilets and bathrooms were not closed at any time of his/her experience													
Toilets and bathrooms were clean during all times of his/her encounter													
Toilets and bathrooms were not shared between male and female													
Discharge planning was addressed during admission which													

at least includes possible days of hospital stay and the cost it may incur													
Pain management was adequate													
Linen was being changed regularly and during times of gross contamination with body fluids													
Adequate supply of hospital gowns and pyjamas													
Did not felt abandoned for long time without care (failure of provide to monitor and intervene when needed)													
The food service was satisfactory													
Adequate water supply during the stay													
Adequate information provided regarding waste segregation, norms of the ward, infection prevention													
Auditory privacy was maintained during times of hospital stay													
All oral medications were kept in cabinet and													

supported to take in the presence of assigned the nurse/midwife													
Not felt incidents of breaks in confidentiality (no information provided to the client him/herself while other family member/visitor was there and whom he/she did not want to be shared with the information)													
Felt good communication and collaboration with in the health care team													
Providers responded promptly and professionally when he/she asks for help													
Perceived that providers are skillful and displayed confidence while providing care or treatment													
Felt served equally irrespective his/her status including gender, age, economic status, social status, place of living, presence of a relative/provider													

he/she knows working in the hospital											
No incidence of detainment in the facility for administrative reasons including unable to pay for services											
Allowed to labor in preferred position	███	███	███	███	███	███	███	███			
Allowed to deliver in preferred position when applicable	███	███	███	███	███	███	███	███			
Trust developed on the overall hospital and recommend it to others to be served											
Total											**Grand total**

N.B: Black shaded – not applicable to the departments at all times

Appendix *9: Essential lab tests availability*

ሠንጠረዥ-9-በሆስፒታልእናበሪጅናልላቦራቶሪደረጃየላብራቶሪየምርመራዝርዝርእስታንዳርድ

ዲፓርትመንት	ቀድሞየነበረእስታንዳርድ በጀነራልሆስፒታልላብራቶሪደረ ጃ	በዚህጥናትበማሻሻያነትየቀረበ		አስታየ ት
		በሆስፒታልላብራቶሪደረ ጃ	በሪጅናል ላብራቶሪደረ ጃ	
Clinical chemistry	Blood glucose	Blood glucose	Blood glucose	
	Alkaline phosphatase	Alkaline phosphatase	Alkaline phosphatas e	
	ALT	ALT	ALT	
	SGPT	SGPT	SGPT	
	SGOT	SGOT	SGOT	
	Total bilirubine	Total bilirubine	Total bilirubine	
	Direct bilirubine	Direct bilirubine	Direct bilirubine	
	Total protein	Total protein	Total protein	
	Albumin	Albumin	Albumin	
	Urea	Urea	Urea	
	Creatinin	Creatinin	Creatinin	
	Uric acid	Uric acid	Uric acid	
		GGT	GGT	
		Cholestrol	Cholestrol	
		Triglyceride	Triglyceride	
		LDL-Cholestrol	LDL-Cholestrol	
		HDL-Cholestrol	HDL-Cholestrol	
			Lipase	
Parasitology	Stool microscopy	Stool microscopy		
	Blood film for malaria and other hemoparasite /	Blood film for malaria and other		

	Malaria Rapid Test	hemoparasite		
		Occult blood		
Urine and body fluid analysis:	Urinalysis	Urinalysis		
	CSF analysis	CSF analysis		
	Ascitic fluid	Ascitic fluid		
	Pleural fluid	Pleural fluid		
Mycology	KOH test	KOH test		
Hematology	Hemoglobin	Hemoglobin	CBC+Diff (All CBC Pofile)	
	Total WBC count	Total WBC count		
	Differential white cell count	Differential white cell count		
	ESR	ESR		
	Hematocrit	Hematocrit		
		Platelet count		
		CBC+Diff (All CBC Pofile)		
Serology:	ASO	ASO	HIV-test	
	RF	RF		
	RPR	RPR		
	HIV-test	HIV-test		
	H.Pylori (Ag/Ab)	H.Pylori (Ag/Ab)		
	HBs Ag	HBs Ag		
	HCV	HCV		
	Salmonella Typhi-O	Salmonella Typhi-O		
	Salmonella Typhi-H	Salmonella Typhi-H		
	Proteus-OX19	Proteus-OX19		
	HCG	HCG		
Blood Group & Compatibilit	Anti-A۰Anti-B۰ Anti- D	Anti-A۰Anti-B۰ Anti-D		
	Cross match	Cross match		

y testing				
		Indirect coomb's test		
Bacteriology	Gram stain	Gram stain	Gram stain	
	ZiehlNeelson stain	ZiehlNeelson stain	ZiehlNeelson stain	
	Indian ink	Indian ink		
		wet smear		
		Culture and Drug sensitivity test	Culture and Drug sensativite test	
Immuno hematology	CD4 count	CD4 count (CD Pannel (CD4, CD8, CD3, ratio...)	CD4 count (CD Pannel (CD4, CD8, CD3, ratio...)	
Anemia panal		ferritin	Ferritin	
		folate III	folate III	
		Iron	Iron	
		RBC FOLATE	RBC FOLATE	
		Vitamin B12	Vitamin B12	
		Transferrin	Transferrin	
		UIBC	UIBC	
Coagullation test	PT	PT	PT	
	Bleeding time	PTT	PTT	
		INR	INR	
		Fibrinogen	Fibrinogen	
		Bleeding time		
Electrolyte	Na	Na	Na+ Serum	
	K	K	K+ Serum	
	Cl	Cl	Cl- Serum	

		Mg		
		PO4	Phospate Serum	
		Ca	Calcium seru	
Fertility		Spermatozoa		
		Pap Smear		
Tumer markers		CA-125	CA-15-3	
		CA-15-3	CA 19-9	
		CA-19-9	CA-19-9	
		CEA		
Molecular tests			Viral load	
			EID (Early infant diagnosis)	
Hormon analysis	T3	T3 (FT3)	T3 (FT3)	
	T4	T4 (FT4)	T4 (FT4)	
	TSH	TSH	TSH	
	FSH	FSH	FSH	
	LH	LH	LH	
		Testesteron	Testesteron	
		Prolactine	Prolactine	
Cardiac marker	LDH	LDH		
	CK-MB	CK-MB		
	Troponine	Troponine		
	CPK	CPK		
Blood gas analysis			Co2	
			PH	
			Po2	

Appendix 10: STAFF SATISFACTION SURVEY TOOL
Survey Protocol: staff Satisfaction
Purpose of Survey:

To provide a standardized survey tool for hospitals, they can use it to monitor staff   satisfaction in their workplace, and changes in satisfaction over time.

The Key Performance Indicator "staff Satisfaction" will be calculated using the average responses to questions in the staff satisfaction survey tool.

Period of Survey:
Hospitals should perform satisfaction of at least 50% of their staffs biannually. The surveys should be done in the first week of the last months of the first and the second half of the budget year (i.e. first weeks of December and June). As indicated in the survey tool, different categories of health care providers (physicians, nurses, midwives, laboratory/pharmacy/imaging workers) and supporting staffs has to be included in the survey.

Role of KPI owner:
The hospital should assign an owner" for the KPI staff Satisfaction (HR or Quality unit staff). He/she is responsible to oversee the survey, to select and train surveyors, to issue surveys to each surveyor, to receive completed surveys from centralized collection area, calculate staff satisfaction (KPI …) and response rate, and give all completed surveys to a data entry person who will enter them into the Access Database.

Selection and role of surveyors:
Each health facility should assign one or more individuals to administer the surveys to staffs. The individual conducting the survey (also referred to as "surveyor") should understand the survey well, including all survey questions and answer choice. A surveyor must have good interpersonal skills to interact sensitively with staffs and must not lead the staffs to particular responses but should administer the survey objectively. Each surveyor must be trained to ensure he/she understands the purpose and process of the surveys. Surveyors are responsible for collecting all completed surveys and returning them to a centralized collection area determined by the health facility. Surveys can be completed by the staff themselves (written).

Staff recruitment:
Participation is voluntary and staff anonymity must be maintained. No identifying information (such as staff's name) should be collected. Staffs should be selected to reflect a diversity of staffs, including physicians, nurses, midwives, laboratory/pharmacy/imaging workers and supporting staffs. The surveyor should not select staffs based on his/her presumptions about whether the staff appears pleased or not pleased with the working environment.

Methodology of Survey:

a) Assign and train surveyors

Selection and training of surveyors should be in accordance with above stated protocol and should be done well in advance of survey period.

b) Select staffs for survey

Surveyors should be provided with a logbook to record the number of staffs asked to participate in survey and the number of surveys actually completed by staffs. This is to measure the survey response rate as well as track surveys.

Staff recruitment should be in accordance with above stated protocol. Surveyor should then approach the staff to inquires if he/she is interested in completing a staff survey. The surveyor should explain the purpose of the survey and assure the staff of his or her anonymity. If the staff does want to participate they must then give their consent verbally before the survey can be administered.

c) Written completion of survey

The survey should be completed by the staff themselves (written). An ID number should be assigned to each survey sequentially as it is conducted. The ID should be entered on the survey form and in a logbook. Surveyors will provide a blank staff satisfaction survey tool to the staff to be completed by him/her. Staff should complete the survey at the time it is distributed and be notified of a centralized collection area where they can return their completed survey. Accordingly, they fill their rating in the satisfaction tool as per the category of their profession.

d) KPI owner calculates Staff Satisfaction rate

At the end of the survey period the KPI owner should collect all completed surveys from the centralized collection area. The KPI owner should calculate Staff Satisfaction using staff answers to question on the survey tool. The formula for the indicator is as follows:

[[Total number of "Neutral" responses + Total number of "satisfied" responses] / [total number of Staff Satisfaction surveys completed x total number of staff satisfaction criteria's evaluated]] x 100%.

e) KPI Owner reports to KPI focal person and Data Entry Person

After calculating Staff Satisfaction the KPI owner should report all data elements and indicator to the KPI focal person. The KPI focal person will then check the calculations and enter them into the KPI report form.

Additionally, all surveys should be given to the appropriate data entry person to enter into the Access Database. See Appendix 10 for guidance.

THANK YOU FOR YOUR COOPERATION!

Date in Ethiopian calendar: date……………………...month……………...year……………………………

Profession / responsibility in the hospital ………………………………………………….

Length of service in the hospital: years…………………………months…………………………………..

Characteristics	Doctors (GPs, specialists)			Nurses / midwives			Laboratory/ pharmacy/ radiology workers			Supporting staffs			Total
	D	N	A	D	N	A	D	N	A	D	N	A	
	D = Disagree N = Neutral A = Agree												
The hospital clearly conveys its mission to its employees.													
I agree with The hospital's overall mission.													
I understand how my job aligns with the hospital mission.													
I feel like I am a part of the hospital													
There is good communication from employees to managers in the hospital.													
There is good communication from managers to employees in the hospital.													
My job gives me the opportunity to learn													
I have the tools and resources I need to do my job.													
I have the training I need to do my job.													
I receive the right amount of recognition for my work.													
I am aware of the advancement opportunities that exist in the hospital for me.													
I feel underutilized in my job													
The amount of work expected of me is reasonable.													
It is easy to get along with my colleagues.													
The morale in my department													

is high.													
People in my department communicate sufficiently with one another													
Get excused for shortcomings													
Overall, my supervisor does a good job.													
My supervisor actively listens to my suggestions.													
My supervisor enables me to perform at my best.													
My supervisor promotes an atmosphere of teamwork.													
It is clear to me what my supervisor expects of me regarding my job performance													
My supervisor evaluates my work performance on a regular basis.													
My supervisor provides me with actionable suggestions on what I can do to improve.													
When I have questions or concerns, my supervisor is able to address them.													
I would recommend this hospital as a good place to work.													
Total													**Grand total**

This template should be used in the preparation phase of the supportive site visit process to provide all team members with information about the hospital. The site visit leader should complete prepare the document and distribute it to team members prior to the site visit.

Site visit briefing document:

Hospital Name: _____ **Region:** _____ **Type of Hospital:** _____

Document prepared by: _____ **Date of completion:** _____

Section 1: Review of hospital data, reports and information			
What data, reports and information have been reviewed? (Tick all that apply)			
Most recent site visit report		Hospital response/action plan to most recent site visit report	
Hospital annual report		Hospital KPI reports	
Partner reports on hospital		Hospital Self-Assessment reports on attainment of EHSTG standards	
Other (please describe)			

Section 2: Site visit briefing notes

Summary of action agreed following previous site visit

Enter here a summary of the action that the hospital was expected to take following the previous site visit (based on the most recent hospital response and action plan)

Describe (if known) whether the hospital has undertaken this action and any issues that remain.

Summary of hospital performance

Enter here a summary of information gathered from the most recent KPI report and EHSTG report

Strengths or successes of hospital

Enter here areas of performance that appear strong based on KPI/EHSTG reports or information gathered from other sources

Areas of possible weakness

Enter here areas of performance that appear weak based on KPI/EHSTG reports or information gathered from other sources

Evidence that requires validation

Enter here any data that should be checked/validated during the site visit. For example selected KPI data or selected EHSTG standards

<u>Areas for investigation</u>

Enter here areas of the hospital that should be investigated during the site visit (based on the information entered above). This could include follow up on actions that should have been completed following the previous site visit, or performance issues that have been identified through the KPI or EHSTG reports.

Be sure to include areas that are possible strengths of the hospital so that best practice can also be identified.

<u>Service areas to be visited</u>

Section 3: Scheduling	
Date of proposed site visit:	
Date hospital CEO informed of site visit:	

Enter here the specific service areas of the hospital that should be visited by members of the site visit team. This will be based on the information entered above. For example, MR Department, Billing Offices/Finance Dept, ER Department, Inpatient Wards etc

<u>Staff members to be interviewed</u>

Enter here the staff members who should be available for interview during the site visit. This should be based on the information entered above. For example, CEO, SMT, Head of MR, Finance Head, ER Case Team Leader, IP Case Team Leader etc

<u>Additional information for the hospital to prepare</u>

Enter here any addition information that the CEO should prepare for your visit. If feasible this information should be sent to the site visit team before the site visit. However if this is not possible then the information may be presented at the opening meeting of the site visit. For example; patient or staff survey results etc

Enter here any unresolved action from the previous site visit. Include a description of progress made by the hospital or RHB (if relevant) to resolve the issue.

The following is a template with guidance for preparing a supportive supervision site visit report. It should be used after conducting a hospital site visit and reviewed by all team members. Once agreed the report should be sent to the hospital CEO for comments. Once finalized the report should be distributed to the RHB and all relevant stakeholders.

Cover Page

Should include region, name of hospital, names of site visit team members, date of site visit and date of report completion

Table of Contents Introduction

This section should include background information about the site supervision process, general hospital information (hospital level, services offered, catchment population, etc.)

Main Findings

This section should provide a summary of the findings of the site supervision team. It informs readers of:

- Key findings from the site visit
- Strengths and improvements made
- Areas for improvement
- Overall progress in implementing hospital reforms (EHSTG, BPR, BSC, etc.)

Recommendations

This section should describe any follow up actions the hospital should take based on the findings of the site supervision team.

Conclusion

Hospital Name: _____ **Region:** _____ **Date of Site Visit:** _____

Site visit team members:

Hospital response:

Enter here any specific comment you have on the Site Visit Report. State if you accept the findings and recommendations of the site visit report.

If there are any observations or comments made in the site visit report that you think are inaccurate describe those here.

Action plan:

Include an action plan that describes:

- *The specific action that the hospital will take to address the recommendations made in the site visit report*
- *The responsible person for each action*
- *The timeline to complete each action*

Support expected from RHB or other partners

Enter here any support or action that you expect the RHB or other partners to take to assist the hospital to fulfill its action plan or to respond to recommendations made by the site visit team.

<u>Suggested areas for review during next site visit</u>

Enter here any suggestions you would like to make to the site visit team for their next visit to the hospital. This could be areas of the hospital that were not reviewed during the current site visit where you would like to demonstrate good practice, or areas where you would like the site visit team to have better understanding of the challenges you face.

<u>Any other comments</u>

Enter here any other comments you have. For example, suggestions on how the site visit process could be improved.