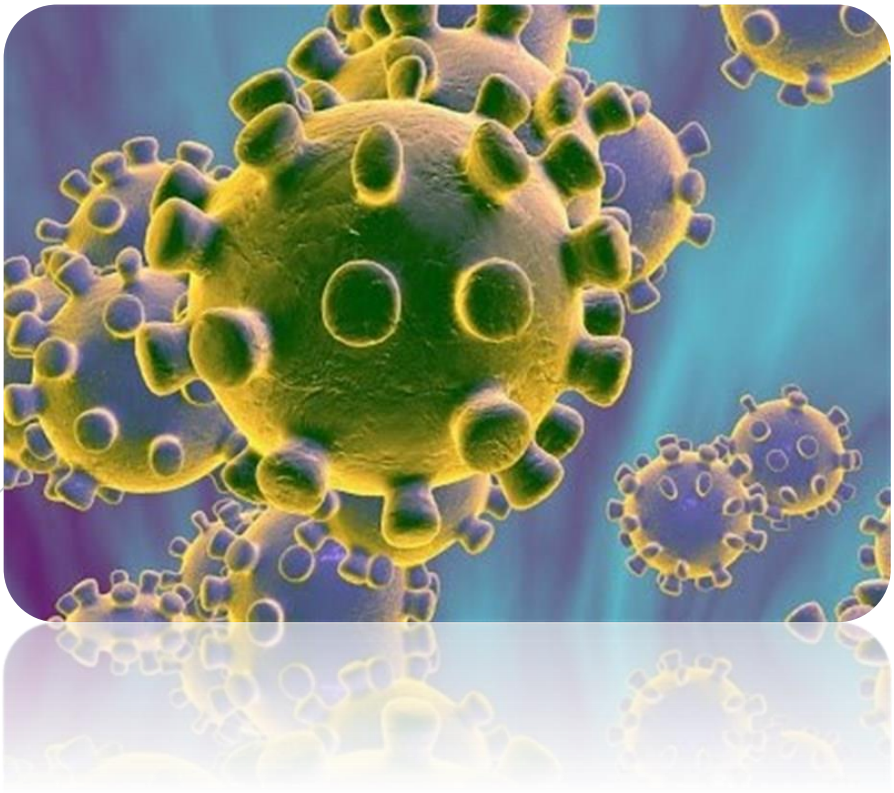
1/31/2021

Hospitals Performance Evaluation Checklist in response to COVID-19 pandemic



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Evaluation team details:

NO.	Name of raters	Job Title

Hospital details:

NO.	details
1	Hospital name:
2	Type of ownership: Government□ Private□ Charity□ Military□ Others □
3	Type of Activity: General□ Specialized□ Teaching□ University□ Others □
4	Number of approved beds: ..... Number of active beds: ……
5	Number of COVID-19 beds: …….
6	Number of increased beds for COVID -19 patients: …….
7	Is this hospital COVID -19 center? Yes□ No□
8	Safety score according to the latest HSI assessment: Total: …….. Structural: …… Non-structural: ……. Functional: …….
9	Hospital Accreditation Grade: Excellent □ one □ two □ three □ not approved □
10	Accreditation score of Disaster Risk Management: …….
11	Date of evaluation: ……/……../…….

Hospital performance during COVID-19 pandemic (past year):

Total admission of Confirmed cases:	
Total recovered:	
Total expired:	
Net mortality rate per 100,000 admissions:	

1- Risk management and planning		Scoring		
		completed	in progress	not started
1-1-	**Incident command**			
1-	The hospital Incident Command System (HICS) or a team is active in the hospital with the goal of managing COVID-19 pandemic. * Recommended team participants: Chief Executive Officer, Chief Administrative Officer, Chief Nursing Officer, Chief Financial Officer, Chief Clinical Supervisor, Training Director, Managing Director of Emergency Services, Infection Control Supervisor, Disaster Coordinator, Chief Human Resources Director, Ethics Consultant, and others after the decision of the Hospital Disaster Risk Management Committee. * At least, each main post in HICS has been considered with 2 substitutes. * Proposed participants might change according to official organization structure.			
2-	The Incident commander has consultants specialized in the field of biological disasters management (including: infectious disease specialist, clinical epidemiologist, clinical pharmacologist, ICU fellowship, clinical lab specialist, radiologist, pulmonologist, ethics consultant, etc.).			
3-	A safe designated place is considered as the hospital Incident Command Center for emergency response management meetings; equipped with communication and meeting facilities.			
4-	Biological Incident action plans (IAP) for COVID-19 pandemic are developed and implemented in accordance with national plans by the incident Command Team.			
5-	Hospital staff are aware of their roles in the Incident Command System and Incident Action Plan during Covid-19 pandemic.			
1-2-	**Planning**			
6-	An active committee is considered to plan for disaster risk management which members are familiar with their job descriptions. * Recommended participants of the committee: Chief Executive Officer, Chief Administrative Officer, Chief Nursing Officer, Chief Medical Services Director, Disaster Coordinator, Safety & Occupational Health Director, Managing Director of Emergency Services, Epidemiologist/Infection Control Supervisor, Clinical Pharmacologist, Laboratory Department Officer, Imaging Department Officer, Security Director, Medical Equipment Director, Engineering and Maintenance Director, Human resources Director, Nutrition Coordinator, Environmental (housekeeping) Services Director, Public Relations Coordinator/Public Information Officer, and others after the decision of the Hospital Disaster Risk Management Committee. * Regular meetings according to COVID-19 situation in the country (at least monthly). * Proposed participants might change according to official organization structure.			
7-	The hospital has a comprehensive disaster risk management plan with all hazards approach and based on risk analysis.			
8-	Comprehensive plan of hospital disaster risk management is allocated in part to epidemics/pandemics.			
9-	There is a plan and preparedness in the hospital for probable scenarios during outbreak of infectious diseases (such as COVID-19 waves, and concurrent outbreak of other common epidemics or infectious diseases in the country).			

		completed	in progress	not started
1-3-	**Concurrent emergencies**			
10-	The Hospital Safety Index (HSI) is in acceptable range (6-10).			
11-	In developing a hospital risk management plan, the probability of concurrent emergencies such as earthquake, flood, explosion, fire, or other disasters has been also considered (especially triage, surge capacity, resources supply, human resource, early warning, and emergency evacuation), and staff are familiar with it.			
12-	The hospital is in coordination with the Emergency Operation Center (EOC) of University/Ministry of Health and other hospitals; to reduce the client burden of other concurrent disasters, and to increase service delivery.			
1-4-	**Performance evaluation**			
13-	Mechanism(s)/checklist(s) is/are considered and conducted for self-assessment of the hospital performance during COVID-19 pandemic.			
14-	Infection prevention and control measures are continuously monitored (by at least a trained supervisor), and corrective measures are conducted.			
15-	The adherence to guidelines and instructions is continuously monitored, and corrective measures are conducted.			
16-	The quality of respiratory care and oxygen supply to COVID-19 inpatients is monitored daily by the hospital management team.			

2- Coordination and communication		Scoring		
2-1-	**Inter- and intra-sectorial coordination**	**completed**	**in progress**	**not started**
17-	A communication system/method is considered for report and effective exchange of data between different units of hospital.			
18-	Information are exchanged transparently between the hospital and EOC of University/Ministry of Health (as rapid and daily reports).			
19-	There is a memorandum of understanding and proper coordination between the hospital and referral laboratories.			
20-	There is a memorandum of understanding and proper coordination between the hospital and forensic medicine organization and the burial facilities.			
2-2-	**Risk communication**			
21-	All information is provided to the public and the media only by the Public Information Officer and after the approval of incident commander.			
22-	Staff are fully familiar with information and communication systems of the hospital.			
23-	Relevant staff and stakeholders receive effectively all decisions about patient prioritization (such as adjusted admission and discharge criteria), infection prevention and control measures, and policies of drugs and vaccine uses.			
24-	The hospital has suitable alternative communication methods (such as landline, internet, mobile phone, pager, satellite phones, two-way radio equipment, contact list).			
25-	Updated staff contact lists are available.			
26-	Virtual methods of informing and communication are considered for the families of patients and staff.			
27-	Draft key messages are available to different audiences (such as patients, staff, and the public) including probable scenarios related to COVID-19 pandemic.			

3- Infection Prevention and control		Scoring		
3-1-	**Infection control**	**completed**	**in progress**	**not started**
28-	The Infection Control Committee is active in hospital and meets continuously during COVID-19 pandemic (at least weekly).			
29-	Personal Protective Equipment (PPE) is handled properly by staff (donning, doffing, and disposal).			
30-	Hand hygiene is done with detergents and alcohol-based disinfectants by hospital staff.			
31-	Medical/surgical masks are used for all Suspect/Probable/Confirmed cases during transport in the hospital.			
32-	Necessary measures have been considered to reduce the infection transmission into the hospital, and route of COVID-19 cases transport is distinct.			
33-	Staff are aware of the admission process and safe route of suspect cases transport (from the examination room to the hospital ward).			
34-	Management of staff occupational exposure is considered and conducted (including examination, quarantine, treatment, and sick leave).			
35-	Infection prevention and control instructions are implemented for laboratory specimens.			
36-	Infection prevention and control instructions are implemented for catering.			
37-	Safe management of the dead body in the context of COVID-19 is conducted in accordance with the infection prevention and control instructions of Health Ministry.			
38-	Hospital ventilation systems and air circulation are standard.			
39-	The rooms, routs, and wards of COVID-19 confirmed cases have been specified and the traffic is controlled.			
40-	Contact tracking process is conducted in the hospital in accordance to the relevant authorities (Ministry of Health).			
41-	Traffic restriction plan for visitors is conducted.			
42-	An obligatory plan is conducted for precautionary measures of infection prevention and control for visitors (similar to staff).			
3-2-	**Isolation**			
43-	Temporary habitation scheme is considered and conducted for staff quarantine at shift intervals.			
44-	Isolated areas/rooms have been considered for examination of suspected cases in outpatient and inpatient wards.			
45-	Hospital has considered individualized isolation of the patients and conducts it.			
46-	Hospital has considered mass isolation* of the patients and conducts it. * COVID-19 cases are hospitalized in a distinct part of unit/ward. The distance between the beds is at least 1.5 meters.			
47-	A plan is considered and conducted for regular monitoring of negative pressure and ventilation of isolated rooms.			

3-3-	**Decontamination**	**completed**	**in progress**	**not started**
48-	Cleaning and disinfection of physical spaces is conducted according to the Ministry of Health instructions.			
49-	Cleaning and disinfection of reusable equipment is conducted according to the Ministry of Health instructions.			
50-	Cleaning and disinfection of clothes is conducted according to the Ministry of Health instructions.			
51-	Cleaning and disinfection of ambulances is conducted according to the Ministry of Health instructions.			
52-	Medical and non-medical waste management of COVID-19 patients is conducted according to the Ministry of Health instructions.			

4- Diagnosis and treatment		Scoring		
4-1-	**Diagnosis**	**completed**	**in progress**	**not started**
53-	COVID-19 detection kits are available according to the number of hospital visitors.			
54-	COVID-19 imaging services are available timely.			
55-	A plan is considered and conducted for laboratory and imaging services as substitute in necessary situations*. * lack of services in the hospital/load of cases.			
56-	The medical staff is aware of diagnostic principles of COVID-19 patients.			
57-	A plan is considered for performing differential diagnostic tests of other respiratory viruses (such as influenza) is considered and conducted in special cases.			
58-	A referral plan is considered and conducted to the reference laboratory in necessary situations (such as changes in virus characteristics, infectivity, transmission, and drug resistance).			
59-	Sampling methods in COVID-19 cases are conducted according to the Ministry of Health instructions.			
60-	COVID-19 laboratory specimens are kept and stored safely.			
61-	Transport of COVID-19 laboratory specimens is conducted safely inside and outside the hospital.			
62-	Laboratory biosafety is provided in accordance with Ministry of Health instructions.			
63-	In the laboratory, the form of registration and follow-up of non-compliance cases is completed, and corrective measures are conducted.			
64-	Surveillance system is considered during COVID-19 pandemic and the relevant staff is actively involved.			
4-2-	**Rapid identification**			
65-	Definitive diagnosis of SARS-CoV-2 takes place in less than 24 hours inside the hospital/48 hours outside the hospital.			
66-	Para-clinical results are provided without delay to hospital physicians and health officials.			
67-	Surveillance results (especially COVID-19) are presented promptly to hospital administrators, health officials, and physicians for future measures.			
4-3-	**Triage in biological events**			
68-	A triage protocol is defined and implemented in accordance with national guidelines (with the aim of diagnosing and classifying cases of COVID-19, isolating severe cases, and prioritizing patients needing ICU).			
69-	Triage protocol requirements have been declared to ambulances suppliers, partner hospitals and related staff.			
70-	Triage is supervised by a trained personnel, and corrective measures are applied.			

4-4-	**Case Management**	**completed**	**in progress**	**not started**
71-	clinical staff are familiar with basic principles of medical and supportive care of COVID-19 cases.			
72-	Admission, treatment, refer, and discharge of Covid-19 patients is carried out in accordance with the latest instructions of Health Ministry.			
73-	Severe COVID-19 cases are admitted and treated in ICU.			
74-	The recovery rate of COVID-19 patients in the hospital is equal to or higher than the national average ratio.			
4-5-	**Clinical ethics**			
75-	Any new therapeutic modality (other than official protocol) is conducted after proposal approval in national ethics committee.			
76-	Special process of medical error reporting in COVID-19 pandemic is considered and announced.			
77-	Medical error reports of the COVID-19 cases are inspected immediately and corrective measures are conducted.			
78-	Patients dissatisfactions are handled in an appropriate manner, and feedback is given.			
4-6-	**Psychological services**			
79-	The psychological needs of patients and staff are constantly monitored during COVID-19 pandemic.			
80-	A psychological support plan is considered and conducted for staff and patients.			
81-	A psychological support plan is considered and conducted for families of staff and patients.			

5- Training and exercises		Scoring		
5-1- Staff training		**completed**	**in progress**	**not started**
82-	COVID-19 official instructions are taught regularly to staff.			
83-	Effective training has been implemented for staff on their job descriptions in COVID-19 pandemic, and they are familiar with it.			
84-	Effective training has been implemented for staff on the principles of infection prevention and control and personal protection (such as modes of transmission, PPE donning and doffing, precautions, isolation, etc), and they are familiar with it.			
85-	Effective training has been implemented for relevant staff on case identification, triage, examination, and patient care, and they are familiar with it.			
86-	Advanced training (resuscitation, intubation, ventilation care, etc.) is provided to medical staff of more responsive wards (infectious diseases ward, emergency department, and ICU).			
87-	A plan for effective training of all new staff (such as reserve personnel, volunteers, retired employees, etc.) is considered on principles of infection prevention and control, personal protection (like modes of transmission, PPE donning and doffing, precautions, isolation, etc.), and case management, and is implemented when needed.			
88-	During the COVID-19 pandemic, relevant and periodic exercises are implemented such as CPR, concurrent emergencies management, and infection prevention and control measures to ensure the staff competency and safety.			
89-	Exercises of spill management is conducted in the laboratory and hospital.			
5-2- Patients and visitors training				
90-	Effective training has been implemented for COVID-19 patients during admission, discharge, and hospitalization.			
91-	Effective training has been implemented for COVID-19 patients and visitors on respiratory hygiene, and cough etiquette.			
92-	Effective training has been implemented for Patients' families on homecare and personal hygiene after discharge.			

6- Resources management		Scoring		
6-1-	**Human resources**	**completed**	**in progress**	**not started**
93-	A plan is considered and conducted for staff motivation (financial and/or non-financial rewards and benefits).			
94-	Appropriate* qualified physicians are provided during COVID-19 pandemic. * According to human recourses standards of health ministry/system in each country.			
95-	Appropriate* qualified nurses are provided during COVID-19 pandemic. * According to human recourses standards of health ministry/system in each country.			
96-	Appropriate* qualified paramedics staff are provided during COVID-19 pandemic. * According to human recourses standards of health ministry/system in each country.			
97-	Appropriate* qualified non-medical staff are provided during COVID-19 pandemic. * According to human recourses standards of health ministry/system in each country.			
98-	Appropriate* qualified securing staff are provided during COVID-19 pandemic. * According to human recourses standards of health ministry/system in each country.			
99-	Appropriate* qualified logistic staff are provided during COVID-19 pandemic. * According to human recourses standards of health ministry/system in each country.			
100-	Training team(s) is/are considered for fast and up-to-date training to all staff, visitors and patients.			
101-	Necessary methods and facilities are considered and conducted for monitoring of staff health.			
102-	Sick staff (COVID-19) are managed within a special process (priority in admission, referral system, etc.).			
103-	Sick leave rules is considered and conducted to confirmed, probable, or suspected staff.			
104-	Sick leave rules is considered and conducted to staff having affected family members.			
105-	Staff absence is estimated and monitored, and reserve staff is provided (especially in more responsive wards such as infectious diseases ward, emergency department, and ICU.			
106-	Plan of extra staff recruitment (including reserve, volunteers, and retired) is considered and conducted based on the need assessment.			
107-	Support services are considered and conducted to staff (care of the child, sick or disabled family member), to increase their work flexibility.			
108-	A plan (including insurance, temporary license, and financial support) is considered and conducted for staff who may work outside their expertise.			
109-	A clinical epidemiologist cooperates with the hospital continuously (formal or consultant).			
110-	Staff having underlying diseases are assigned in non-COVID wards.			
6-2-	**Logistics and supplies**			
111-	Equipment, supplies, and medicines are listed and is updated at regular intervals.			
112-	The needed amount of equipment, supplies, and medicines has been estimated and provided (according to COVID-19 pandemic scenarios, at least for one month).			
113-	The environment of equipment, supplies, and medicines storage is safe and appropriate (including access, security, temperature, ventilation, humidity, and light).			

Logistics and supplies (continued)		**completed**	**in progress**	**not started**
114-	A plan is considered and conducted for monitoring of equipment, supplies, and medicines (warning systems for shortage and expiry date).			
115-	The cold chain is maintained for necessary items.			
116-	PPE (mask, gloves, gown, goggles, face shield, etc.) is provided according to the risk level, for at least one month.			
117-	Front line staff are prioritized for PPE.			
118-	An agreement has been considered with suppliers to ensure the immediate provision of equipment, supplies, and medicines in emergencies.			
119-	A mechanism is considered for maintenance and rapid repair of equipment (such as ventilators, etc.).			
120-	Transfer services are provided during COVID-19 pandemic for patient referral and dispatch.			
121-	Necessary laboratory materials and equipment are provided for one month at least.			
122-	Necessary imaging equipment and materials are provided for one month at least.			
123-	Detergents and alcohol-based hand rubs are provided for hand hygiene, for one month at least.			
124-	Detergents are provided for cleaning and disinfecting physical spaces, for one month at least.			
125-	Medical and non-medical waste disposal facilities are provided for one month at least (especially in the laboratory, ICU, emergency department, and COVID-19 wards).			
126-	Hygiene, medical, and care facilities and PPE are provided at the staff quarantine place, for one month at least.			
127-	Essential support services (including water, foods, electricity, medical gases, fuel) are provided in proportion to admission capacity and increasing demand.			
128-	Security of hospital entrance, warehouses, traffic, and parking is provided.			
129-	Equipment and contents are provided for effective training of staff, patients and visitors.			
130-	Sufficient clean clothes and sheets are provided.			
131-	Sufficient corpse bags (and shrouds) are provided.			
6-3-	**Physical resources**			
132-	A place is considered for triage of COVID-19 cases (preferably outside the main hospital building).			
133-	An enclosed and isolated area has been considered for waiting and examination of suspected cases at the entrance of emergency department; which is well ventilated, low traffic, and safe.			
134-	ICU is considered for COVID-19 severe cases according to Ministry of Health standards. * One ICU bed for every 5 hospitalized cases.			
135-	Proper ward(s) is/are considered for patient isolation in accordance with Ministry of Health standards*. * Includes exclusive isolated rooms having proper ventilation (air change more than 12 times per hour), negative pressure (for aerosol generating procedures), and pre-entry corridor.			
136-	A proper space is considered for storing additional resources and materials.			
137-	A proper place has been considered as a temporary morgue.			

		completed	in progress	not started
6-4-	**Surge capacity**			
138-	Demand increase for hospital services has been estimated by appropriate methods (such as assumptions, pandemic progression rate, epidemiologist opinion, planning tools, etc) during COVID-19 pandemic.			
139-	Hospital surge capacity plan (including physical space, staff, equipment, processes, Dietary (food) services, and elective procedures cancelation) is considered and conducted when needed.			
140-	Staff are familiar with hospital surge capacity plan and aware of their role.			
141-	Gaps in the provision of medical and care services to COVID-19 patients (emphasizing on critical care) are identified and solved with cooperation of health authorities and partner hospitals.			
142-	Capacity has been surged by outsourcing elective and non-critical patients to appropriate partners.			
143-	In the hospital, extra spaces has been identified and equipped as COVID-19 ward(s).			
144-	Alternatives to providing essential support services (water, food, medical gases, electricity, and fuel) is considered.			
6-5-	**Continuity of services**			
145-	Essential medical services are provided continuously for non-COVID-19 patients.			
146-	Continuity of essential support services (water, food, medical gases, electricity, and fuel) has been ensured.			
147-	Continuity of disinfectants supply has been ensured in context of COVID-19 pandemic.			
148-	Continuity of providing essential equipment, supplies, and medicines has been ensured.			
149-	Continuity of supplying trained and qualified staff has been ensured.			
6-6-	**Financial resources**			
150-	Appropriate budget has been allocated to meet the essential needs during COVID-19 pandemic.			
151-	Appropriate insurance services are provided to support staff during COVID-19 pandemic.			
152-	Appropriate insurance services are provided to support resources and hospital totally during COVID-19 pandemic.			

How to calculate total score:

Considering the three-choice scale (completed, in progress, not started) for the tool and its normative nature, the linear conversion method (based on the number 100) was chosen as a guide for evaluating scores and judging the checklist performance. The standard performance score of hospitals was calculated by the formula:

LT = (NH-Nmin) / (Nmax-Nmin) x 100
NH = The raw score of the hospital performance, Nmin = The minimum checklist score,
Nmax = The maximum checklist score, and LT = The standardized score of hospital performance.
The following 4-part scale was selected for judging hospitals' performance: "poor (0-24.9), moderate (25-49.9), good (50-74.9) and excellent (75-100)".

NH	L.T	Performance
380-456	75-100	excellent
304-379.9	50-74.9	good
228-303.9	25-49.9	moderate
159-227.9	0-24.9	poor