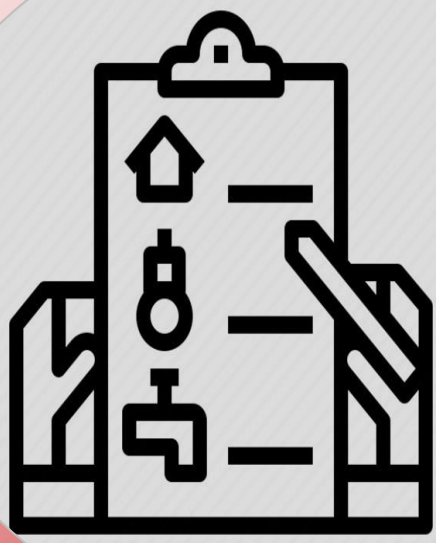
OHSC

Office of Health Standards Compliance

Ensuring quality and safety in health care

Regulatory District Hospital Inspection Tool v1.4



Maternity Ward

Facility: Date:

- **Tool Name:** Regulatory District Hospital Inspection Tool v1.4
- **HEs Type:** Hospitals
- **Sector:** Public
- **Specialization:** District
- **Created By:** Health Standards Development and Training

13 Maternity Ward

Domain 13.2 CLINICAL GOVERNANCE AND CLINICAL CARE

Sub Domain 13.2.1 6 User health records and management.

Standard 13.2.1.1 6(1) The health establishment must ensure that health records of health care users are protected, managed and kept confidential in line with section 14, 15 and 17 of the Act.

Criterion 13.2.1.1.1 6(2)(b) The health establishment must ensure confidentiality of health records.

13.2.1.1.1.1 Confidentiality of health records is maintained.

Assessment type: Observation - **Risk rating:** Essential measure

In line with section 14 of the National Health Act. Observe how user health records are managed in various areas within the unit (this will include but is not limited to public areas, clinical areas) and determine whether unauthorised individuals would not be able to access the information in the health records. This will include the health records of users waiting to be seen, users who have already been seen but their records have not yet been returned to the records storage area/room, health records being used for clinical audit or other administrative purposes, or health records outside the records storage area/room for any other reason. Such records should be kept in a manner which safeguards against unauthorised access to the content of the record. User records may be placed at the foot end of the bed but must not be left open for people to be able to read them when a health care provider is not present. Electronic records must be safeguarded with passwords or any other security measures.

Not applicable: Never

Score	Comment

Standard 13.2.1.2 6(3) The health establishment must create and maintain a system of health records of users in accordance with the requirements of section 13 of the Act.

Criterion 13.2.1.2.1 6(4)(b) The health establishment must record information relating to the examination and health care interventions of users.

13.2.1.2.1.1 Initial labour assessment is recorded.

Assessment type: Patient record audit - **Risk rating:** Vital measure

Select the completed labour records of three users who have delivered at the time of inspection and verify whether each of the aspects listed below has been recorded. Score 1 if the aspect is recorded and 0 if not recorded. Score not applicable for elective caesarean section.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment

Heading: Observation chart when the diagnosis of labour is doubtful completed comprehensively (where applicable).		
1. Assessment date		
2. Assessment time		
3. Assessment of mother		
4. Assessment of fetus		
5. Per vaginal examination		
6. Checklist (This includes maternal, fetal condition and treatment plan)		
7. Discharge checklist		
8. Plan (if not discharged)		
Heading: Labour Initial Assessment when the diagnosis of labour is certain completed comprehensively. Explanatory note: Not applicable for users who were referred and had labour initial assessment done by referring health establishment.		
9. Assessment date		
10. Assessment time		
11. Time of admission		
12. Date and time: Onset of labour		
13. Antenatal information. Explanatory note: This includes but is not limited to ANC attended, Gestational age, Rh factor, problems at ANC.		
14. Main complaints		
15. General examination		
16. Abdominal examination		
17. Per vaginal examination		
18. Risk factors		
19. Summary of diagnosis and management		
20. Details of health care provider who assessed the user		

Unit 2 User health record 2

Aspects	**Score**	**Comment**
Heading: Observation chart when the diagnosis of labour is doubtful completed comprehensively (where applicable).		
1. Assessment date		
2. Assessment time		

3. Assessment of mother		
4. Assessment of fetus		
5. Per vaginal examination		
6. Checklist (This includes maternal, fetal condition and treatment plan)		
7. Discharge checklist		
8. Plan (if not discharged)		
Heading: Labour Initial Assessment when the diagnosis of labour is certain completed comprehensively. Explanatory note: Not applicable for users who were referred and had labour initial assessment done by referring health establishment.		
9. Assessment date		
10. Assessment time		
11. Time of admission		
12. Date and time: Onset of labour		
13. Antenatal information. Explanatory note: This includes but is not limited to ANC attended, Gestational age, Rh factor, problems at ANC.		
14. Main complaints		
15. General examination		
16. Abdominal examination		
17. Per vaginal examination		
18. Risk factors		
19. Summary of diagnosis and management		
20. Details of health care provider who assessed the user		

Unit 3 User health record 3

Aspects	**Score**	**Comment**
Heading: Observation chart when the diagnosis of labour is doubtful completed comprehensively (where applicable).		
1. Assessment date		
2. Assessment time		
3. Assessment of mother		
4. Assessment of fetus		
5. Per vaginal examination		

6. Checklist (This includes maternal, fetal condition and treatment plan)		
7. Discharge checklist		
8. Plan (if not discharged)		
Heading: Labour Initial Assessment when the diagnosis of labour is certain completed comprehensively. **Explanatory note: Not applicable for users who were referred and had labour initial assessment done by referring health establishment.**		
9. Assessment date		
10. Assessment time		
11. Time of admission		
12. Date and time: Onset of labour		
13. Antenatal information. Explanatory note: This includes but is not limited to ANC attended, Gestational age, Rh factor, problems at ANC.		
14. Main complaints		
15. General examination		
16. Abdominal examination		
17. Per vaginal examination		
18. Risk factors		
19. Summary of diagnosis and management		
20. Details of health care provider who assessed the user		

13.2.1.2.1.2 The assessment and management of labour is comprehensively recorded in the maternity case record.

Assessment type: Patient record audit - **Risk rating:** Vital measure
Select the completed partograms and labour records of three users who have delivered at the time of inspection or health records from the previous month and verify whether each of the aspects listed below has been recorded in accordance with national guidelines. Score 1 if the aspect is recorded and 0 if not recorded. Score not applicable for elective caesarean sections.

Score	**Comment**

Unit 1 User health record 1

Aspects	**Score**	**Comment**
Partogram		
1. Obstetric information (e.g. Gravidity, Parity, Gestation)		

2. Fetal condition		
3. Progress of labour		
4. Contractions		
5. Maternal condition		
6. Time of assessment		
7. Management/ Medication/ I.V Fluids		
8. Pain relief administered		
9. Signature and designation of clinician.		
Summary of labour		
10. Labour from full dilatation to delivery		
11. Summary of duration of labour		
12. Pain relief		
13. Neonatal details		
14. Third stage of labour: Placenta, Membranes and Cord		
15. Fourth stage (First two hours after delivery)		

Unit 2 User health record 2

Aspects	**Score**	**Comment**
Partogram		
1. Obstetric information (e.g. Gravidity, Parity, Gestation)		
2. Fetal condition		
3. Progress of labour		
4. Contractions		
5. Maternal condition		
6. Time of assessment		
7. Management/ Medication/ I.V Fluids		
8. Pain relief administered		
9. Signature and designation of clinician.		
Summary of labour		

10. Labour from full dilatation to delivery		
11. Summary of duration of labour		
12. Pain relief		
13. Neonatal details		
14. Third stage of labour: Placenta, Membranes and Cord		
15. Fourth stage (First two hours after delivery)		

Unit 3 User health record 3

Aspects	**Score**	**Comment**
Partogram		
1. Obstetric information (e.g. Gravidity, Parity, Gestation)		
2. Fetal condition		
3. Progress of labour		
4. Contractions		
5. Maternal condition		
6. Time of assessment		
7. Management/ Medication/ I.V Fluids		
8. Pain relief administered		
9. Signature and designation of clinician.		
Summary of labour		
10. Labour from full dilatation to delivery		
11. Summary of duration of labour		
12. Pain relief		
13. Neonatal details		
14. Third stage of labour: Placenta, Membranes and Cord		
15. Fourth stage (First two hours after delivery)		

13.2.1.2.1.3 The assessment of newborn is comprehensively documented.

Assessment type: Patient record audit - **Risk rating:** Vital measure
Select the completed labour records for three users who have delivered at the time of inspection or health records from the previous month and verify whether each of the aspects listed below has been recorded. Score 1 if the aspect is recorded and 0 if not recorded.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. First examination of neonate		
2. Examined by		
3. Checked by		
4. Date		
5. Time		
Assessment of newborn recorded comprehensively		
6. Gender		
7. Birth weight		
8. Head circumference		
9. Gestational age score		
10. APGAR Score		
11. Resuscitation (where applicable)		
12. Routine care		
13. Mode of delivery		
14. Treatment given		
15. Risk factors to baby		
16. Problems during newborn period		
17. Preventative care		
18. Feeding		
19. Follow up plans		
20. Identification		

Unit 2 User health record 2

Aspects	Score	Comment

1. First examination of neonate		
2. Examined by		
3. Checked by		
4. Date		
5. Time		
Assessment of newborn recorded comprehensively		
6. Gender		
7. Birth weight		
8. Head circumference		
9. Gestational age score		
10. APGAR Score		
11. Resuscitation (where applicable)		
12. Routine care		
13. Mode of delivery		
14. Treatment given		
15. Risk factors to baby		
16. Problems during newborn period		
17. Preventative care		
18. Feeding		
19. Follow up plans		
20. Identification		

Unit 3 User health record 3

Aspects	**Score**	**Comment**
1. First examination of neonate		
2. Examined by		
3. Checked by		
4. Date		
5. Time		

Assessment of newborn recorded comprehensively		
6. Gender		
7. Birth weight		
8. Head circumference		
9. Gestational age score		
10. APGAR Score		
11. Resuscitation (where applicable)		
12. Routine care		
13. Mode of delivery		
14. Treatment given		
15. Risk factors to baby		
16. Problems during newborn period		
17. Preventative care		
18. Feeding		
19. Follow up plans		
20. Identification		

13.2.1.2.1.4 The postnatal assessment of the mother and baby is comprehensively documented.

Assessment type: Patient record audit - **Risk rating:** Vital measure
Select three maternity case records of users who have delivered at the time of inspection or from the previous month and verify whether puerperium notes have been documented. Score 1 if notes are recorded and 0 if not recorded.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Notes for mother		
2. Notes for baby		
3. Date of entry		
4. Time of entry		
5. Details of health care provider.		

Unit 2 User health record 2

Aspects	Score	Comment
1. Notes for mother		
2. Notes for baby		
3. Date of entry		
4. Time of entry		
5. Details of health care provider.		

Unit 3 User health record 3

Aspects	Score	Comment
1. Notes for mother		
2. Notes for baby		
3. Date of entry		
4. Time of entry		
5. Details of health care provider.		

13.2.1.2.1.5 The management of a user who had a caesarean section delivery is documented.

Assessment type: Patient record audit - **Risk rating:** Vital measure

Select the records of three users who had a caesarean section delivery in the labour ward theatre at the time of inspection or health records from the previous month. Verify whether all aspects listed below have been recorded. Score 1 if the aspect is recorded and 0 if not recorded. Not applicable: Where the labour ward health care providers are not responsible for the caesarean section performed in labour ward theatre.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Date of surgery		
2. Time of surgery		
3. Type of anaesthetic		
4. Name of surgeon(s)		
5. Name of assistant surgeon		
6. Name of Anaesthetist		
7. Name of theatre scrub nurse or midwife.		

8. Incision site		
9. Description of findings (This will include but is not limited to state of liquor and state of the uterus).		
10. Details of additional procedures performed (where applicable)		
11. Sutures used.		
12. Description of any difficulties or complications encountered (where applicable)		
13. Placental implantation		
14. Placenta checked for completeness.		
15. Membranes checked for completeness.		
16. Estimated blood loss		
17. Intravenous fluid administered (This could be in the anaesthetic report/record)		
18. Medicine administered (This could be in the anaesthetic report/record)		
19. Resuscitation of the baby (where applicable)		
20. Post-operative instructions		

Unit 2 User health record 2

Aspects	**Score**	**Comment**
1. Date of surgery		
2. Time of surgery		
3. Type of anaesthetic		
4. Name of surgeon(s)		
5. Name of assistant surgeon		
6. Name of Anaesthetist		
7. Name of theatre scrub nurse or midwife.		
8. Incision site		
9. Description of findings (This will include but is not limited to state of liquor and state of the uterus).		
10. Details of additional procedures performed (where applicable)		
11. Sutures used.		
12. Description of any difficulties or complications encountered (where applicable)		
13. Placental implantation		

14. Placenta checked for completeness.		
15. Membranes checked for completeness.		
16. Estimated blood loss		
17. Intravenous fluid administered (This could be in the anaesthetic report/record)		
18. Medicine administered (This could be in the anaesthetic report/record)		
19. Resuscitation of the baby (where applicable)		
20. Post-operative instructions		

Unit 3 User health record 3

Aspects	**Score**	**Comment**
1. Date of surgery		
2. Time of surgery		
3. Type of anaesthetic		
4. Name of surgeon(s)		
5. Name of assistant surgeon		
6. Name of Anaesthetist		
7. Name of theatre scrub nurse or midwife.		
8. Incision site		
9. Description of findings (This will include but is not limited to state of liquor and state of the uterus).		
10. Details of additional procedures performed (where applicable)		
11. Sutures used.		
12. Description of any difficulties or complications encountered (where applicable)		
13. Placental implantation		
14. Placenta checked for completeness.		
15. Membranes checked for completeness.		
16. Estimated blood loss		
17. Intravenous fluid administered (This could be in the anaesthetic report/record)		
18. Medicine administered (This could be in the anaesthetic report/record)		
19. Resuscitation of the baby (where applicable)		
20. Post-operative instructions		

Standard 13.2.1.3 6(5) The health establishment must have a formal process to be followed when obtaining informed consent from the user.

Criterion 13.2.1.3.1 6 A documented procedure which describes the information to be collected and discussed during the process to obtain informed consent is implemented, in accordance with Chapter 2 of the National Health Act (Section 7).

13.2.1.3.1.1 Informed consent forms are completed correctly.

Assessment type: Patient record audit - **Risk rating:** Vital measure

Select three health records of users who were seen at the time of inspection or health records from the previous three months and an informed consent for an operation, procedure or treatment was signed. Check whether the details listed below are recorded on the consent forms. Score 1 if recorded and 0 if it is not recorded.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Names and surname of user		
2. Age, Identity number or date of birth of user		
3. The exact nature of operation/ procedure or treatment, including side, where relevant.		
4. Consent form is signed by user, the legal guardian or any person legally responsible for the user. Explanatory note: Signatory providing consent is legally entitled to give informed consent in accordance with section 7 of the National Health Act 61 of 2003, HPCSA, Booklet 4 and Section 129 of the Children's Act 38 of 2005.		
5. Consent form is signed by health care provider obtaining the consent. Explanatory note: This must be a health care provider legally entitled to obtain the consent in accordance with HPCSA booklet 4, section 4.		
6. Consent form is dated.		
7. All entries on form are legible.		

Unit 2 User health record 2

Aspects	Score	Comment
1. Names and surname of user		
2. Age, Identity number or date of birth of user		
3. The exact nature of operation/ procedure or treatment, including side, where relevant.		
4. Consent form is signed by user, the legal guardian or any person legally responsible for the user. Explanatory note: Signatory providing consent is legally entitled to give informed consent in accordance with section 7 of the National Health Act 61 of 2003, HPCSA, Booklet 4 and Section 129 of the Children's Act 38 of 2005.		

5. Consent form is signed by health care provider obtaining the consent. Explanatory note: This must be a health care provider legally entitled to obtain the consent in accordance with HPCSA booklet 4, section 4.		
6. Consent form is dated.		
7. All entries on form are legible.		

Unit 3 User health record 3

Aspects	Score	Comment
1. Names and surname of user		
2. Age, Identity number or date of birth of user		
3. The exact nature of operation/ procedure or treatment, including side, where relevant.		
4. Consent form is signed by user, the legal guardian or any person legally responsible for the user. Explanatory note: Signatory providing consent is legally entitled to give informed consent in accordance with section 7 of the National Health Act 61 of 2003, HPCSA, Booklet 4 and Section 129 of the Children's Act 38 of 2005.		
5. Consent form is signed by health care provider obtaining the consent. Explanatory note: This must be a health care provider legally entitled to obtain the consent in accordance with HPCSA booklet 4, section 4.		
6. Consent form is dated.		
7. All entries on form are legible.		

Standard 13.2.1.4 6(6) The health establishment must issue a discharge report to users in accordance with section 10 of the Act.
Criterion 13.2.1.4.1 6 Comprehensive discharge reports must be provided to users to ensure continuity of care.

13.2.1.4.1.1 Users are issued with a discharge report.

Assessment type: Patient record audit - **Risk rating:** Vital measure
Select the health records of three users who were discharged at the time of inspection or health records from the previous month and verify whether the discharge report includes the aspects listed below. Score 1 if compliant and 0 if not compliant or if there is no discharge report available.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Name and surname of user		
2. Date of birth or identity number or passport or patient registration/unique identifier.		
3. Date of delivery		
4. Date of discharge		
5. Type of delivery		

6. Name of unit to which user was admitted (this may be a name or alphanumeric details)		
7. Examination on discharge		
8. Family planning		
9. Feeding options		
10. Discharge medication		
11. Advice on discharge.		
Information regarding the baby:		
12. Gender		
13. Weight		
14. Head circumference in centimetres		
15. Length in centimetres		
16. BCG vaccination status		
17. Polio vaccination status		
18. Health care provider name		
19. Health care provider designation		
20. Health care provider signature		
21. Date signed by health care provider		

Unit 2 User health record 2

Aspects	**Score**	**Comment**
1. Name and surname of user		
2. Date of birth or identity number or passport or patient registration/unique identifier.		
3. Date of delivery		
4. Date of discharge		
5. Type of delivery		
6. Name of unit to which user was admitted (this may be a name or alphanumeric details)		
7. Examination on discharge		
8. Family planning		
9. Feeding options		
10. Discharge medication		
11. Advice on discharge.		

Information regarding the baby:		
12. Gender		
13. Weight		
14. Head circumference in centimetres		
15. Length in centimetres		
16. BCG vaccination status		
17. Polio vaccination status		
18. Health care provider name		
19. Health care provider designation		
20. Health care provider signature		
21. Date signed by health care provider		

Unit 3 User health record 3

Aspects	**Score**	**Comment**
1. Name and surname of user		
2. Date of birth or identity number or passport or patient registration/unique identifier.		
3. Date of delivery		
4. Date of discharge		
5. Type of delivery		
6. Name of unit to which user was admitted (this may be a name or alphanumeric details)		
7. Examination on discharge		
8. Family planning		
9. Feeding options		
10. Discharge medication		
11. Advice on discharge.		
Information regarding the baby:		
12. Gender		
13. Weight		
14. Head circumference in centimetres		
15. Length in centimetres		
16. BCG vaccination status		

17. Polio vaccination status		
18. Health care provider name		
19. Health care provider designation		
20. Health care provider signature		
21. Date signed by health care provider		

Sub Domain 13.2.2 7 Clinical management.

Standard 13.2.2.1 7(2) (b) A health establishment must establish and maintain systems, structures and programmes to manage clinical risk.

Criterion 13.2.2.1.1 7 The health establishment must implement systems to ensure that blood and blood products are available and administered safely.

13.2.2.1.1.1 Emergency blood is available in a designated area on site.

Assessment type: Observation - **Risk rating:** Vital measure

To meet this requirement, O-negative blood must be available on site. This blood may be found in the South African National Blood Service (SANBS) refrigerator. The health establishment may choose an area such as the emergency unit, theatre or ICU in which to store the blood.

Not applicable: Where emergency blood is not kept in the unit.

Score	Comment

13.2.2.1.1.2 Administration of blood is recorded.

Assessment type: Patient record audit - **Risk rating:** Vital measure

Select the health records of three users admitted in the unit or health records from the previous month of users who had blood administered and verify whether the aspects listed below are documented. Score 1 if the aspect is documented and 0 if not documented. Score Not applicable if there were no users who had blood administered.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Clinical indication for blood		
2. Type of blood required.		
3. Informed consent completed and signed.		
4. User documentation checked prior to administration of blood. Explanatory note: The blood type, rhesus factor, date when blood was donated, and expiry date must be crosschecked with the user information prior to administration of blood.		
5. Confirmation of user identity prior to administration of blood.		
6. User vital signs documented prior to administration.		

7. User vital signs documented during administration of blood.		
8. User vital signs documented post administration of blood.		
9. Details of transfusion documented. Explanatory note: This must include the start and finish time, how many units were administered, any reaction, and observations.		

Unit 2 User health record 2

Aspects	**Score**	**Comment**
1. Clinical indication for blood		
2. Type of blood required.		
3. Informed consent completed and signed.		
4. User documentation checked prior to administration of blood. Explanatory note: The blood type, rhesus factor, date when blood was donated, and expiry date must be crosschecked with the user information prior to administration of blood.		
5. Confirmation of user identity prior to administration of blood.		
6. User vital signs documented prior to administration.		
7. User vital signs documented during administration of blood.		
8. User vital signs documented post administration of blood.		
9. Details of transfusion documented. Explanatory note: This must include the start and finish time, how many units were administered, any reaction, and observations.		

Unit 3 User health record 3

Aspects	**Score**	**Comment**
1. Clinical indication for blood		
2. Type of blood required.		
3. Informed consent completed and signed.		
4. User documentation checked prior to administration of blood. Explanatory note: The blood type, rhesus factor, date when blood was donated, and expiry date must be crosschecked with the user information prior to administration of blood.		
5. Confirmation of user identity prior to administration of blood.		
6. User vital signs documented prior to administration.		
7. User vital signs documented during administration of blood.		
8. User vital signs documented post administration of blood.		

9. Details of transfusion documented. Explanatory note: This must include the start and finish time, how many units were administered, any reaction, and observations.		

Criterion 13.2.2.1.2 7 Systems must be in place to facilitate user identification.

13.2.2.1.2.1 All users admitted in the unit wear identity bands.

Assessment type: Observation - **Risk rating:** Essential measure
Select three users in the unit and verify whether they are wearing identity bands in accordance with standard operating procedure. Score 1 if users are wearing identification and 0 if not.

Score	**Comment**

Aspects	**Score**	**Comment**
1. User 1		
2. User 2		
3. User 3		

Criterion 13.2.2.1.3 7 The management of emergency resuscitations must be guided and monitored to improve user outcomes.

13.2.2.1.3.1 Emergency trolley is stocked with the medicines, medical supplies and equipment.

Assessment type: Observation - **Risk rating:** Non-negotiable measure
Inspect the contents of the emergency trolley against the aspects listed below. Score 1 if the aspect listed is available, functional and not expired (if applicable) and score 0 if the aspect is not available, not functional or expired (if applicable).

Score	**Comment**

Aspects	**Score**	**Comment**
Devices to open and protect airway		
1. Laryngoscope handle – (As determined by the user profile seen in the unit)		
2. Straight blades for laryngoscope (a minimum of two different sizes as determined by the user profile seen in the unit and resuscitation protocol)		
3. Curved blades for laryngoscope (a minimum of two different sizes as determined by the user profile seen in the unit and resuscitation protocol)		
4. Endotracheal tubes- neonatal (a minimum of three different sizes)		
5. Endotracheal tubes- adult (a minimum of three different sizes)		
6. Oropharyngeal airway (a minimum of three different sizes as determined by the user profile seen in the unit and resuscitation protocol)		
7. Plaster or ties for endotracheal tubes		
8. Lubricating gel		
Equipment for difficult Intubation		
9. Introducer		

10. Laryngeal mask airway (a minimum of three different sizes as determined by the user profile seen in the unit and resuscitation protocol)		
11. Magill forceps (adult)		
12. Magill forceps (neonatal)		
Devices to deliver oxygen/ventilate users		
13. Manual resuscitator device or bag and valve mask (adult)		
14. Manual resuscitator device or bag and valve mask (neonatal)		
15. Oxygen masks- re breather (adult)		
Devices to gain intravascular access		
16. Intravenous administration sets		
17. IV Cannulae (a minimum of three different sizes that accommodate both adult and neonatal users)		
Medicine		
18. Emergency medicines according to local protocol are available and have not expired.		
Equipment to diagnose and treat cardiac dysrhythmias.		
19. Automated external defibrillator (AED) with pads or defibrillator with pads, paddles, conducting gel, pads, paddles and electrodes		
20. Cardiopulmonary Resuscitation board		

13.2.2.1.3.2 Medical supplies and equipment for resuscitation is available.

Assessment type: Observation - **Risk rating:** Vital measure

Inspect whether medical supplies and equipment used for resuscitation is available. The items may be available in the trolley or vicinity of the trolley. Score 1 if the aspect listed is available, functional and not expired (if applicable) and score 0 if the aspect is not available, not functional or expired (if applicable).

Score	**Comment**

Aspects	**Score**	**Comment**
1. Chlorhexidine or Alcohol swabs		
2. Eye protection		
3. Facemasks		
4. Gloves		
5. Spare batteries for laryngoscope		
6. Spare bulb (where applicable)		
7. Syringes (a minimum of five different sizes)		

8. Catheter tip syringe 50ml		
9. Needles (a minimum of five different sizes)		
10. Scissors		
11. Tourniquet		
12. Stethoscope		
13. Nasogastric tube (a minimum of four different sizes as determined by the user profile seen in the unit)		
14. Suction catheter (a minimum of four different sizes as determined by the user profile seen in the unit)		
15. Suction devices (portable)		
16. Yankhauer suction		
17. Nasal cannula		
18. Blood administration set		
19. Local resuscitation protocol or resuscitation algorithm		

13.2.2.1.3.3 The emergency trolley and emergency equipment is checked in accordance with agreed unit practice.

Assessment type: Document - **Risk rating:** Vital measure
Request a documented practice for checking the emergency trolley and verify whether it is checked as documented. This must also include checking of the defibrillator/Automated External Defibrillator.
Request documented records of checking from the previous month.
Not applicable: Never

Score	Comment

Criterion 13.2.2.1.4 7 Medical equipment management systems must be in place to minimise the risk of patient safety incidents related to medical equipment.

13.2.2.1.4.1 Health care personnel receive training on the use of medical equipment.

Assessment type: Document - **Risk rating:** Essential measure
This includes, but is not limited to, orientation records demonstrating that in-service training or training by the supplier of new equipment has been conducted. Training must be provided for each health care personnel for each item of equipment they will be required to use in the course of performing their duties.
Not applicable: Where there was no new equipment introduced in the past twelve months.

Score	Comment

Criterion 13.2.2.1.5 7 Procedures to minimise the risk of health care-associated infections must be implemented.

13.2.2.1.5.1 The storage of sterile packs ensures the integrity of materials.

Assessment type: Observation - **Risk rating:** Essential measure

The manner in which sterile packs are stored must prevent physical damage to packages, avoid exposure of packages to moisture. Packages should not be stored in a manner that will crush, bend, puncture, or compress them. Therefore, packs should not be wet or have water damage, they should be intact (not opened or torn).
Not applicable: Where sterile packs are not kept in the unit.

Score	Comment

Criterion 13.2.2.1.6 7 The management of used and soiled linen must meet infection prevention and control requirements.

13.2.2.1.6.1 The unit has a designated, access-controlled area for the storage of dirty linen.

Assessment type: Observation - **Risk rating:** Essential measure
The area used to store dirty linen must have a door.
Not applicable: Never

Score	Comment

Criterion 13.2.2.1.7 7 The health establishment must have a functional quality management system

13.2.2.1.7.1 Quality improvement plans are developed by health care personnel.

Assessment type: Document - **Risk rating:** Vital measure
Request the quality improvement plan of the unit from the previous six months. Verify whether the aspects listed below are documented. Score 1 (added) if aspect is documented and 0 if not. Not applicable: Where no gaps have been identified.

Score	Comment

Aspects	Score	Comment
1. Gaps identified		
2. Activities required to address gaps		
3. Health care personnel responsible		
4. Time frames		

13.2.2.1.7.2 Corrective action has been taken to improve the quality of service provided where gaps are identified.

Assessment type: Document - **Risk rating:** Vital measure
Evidence must be available that the action specified in the quality improvement plan was implemented.
Not applicable: Where there were no gaps identified.

Score	Comment

Sub Domain 13.2.3 8 Infection prevention and control programmes.
Standard 13.2.3.1 8(1) The health establishment must maintain an environment, which minimises the risk of disease outbreaks, the transmission of infection to users, health care personnel and visitors.

Criterion 13.2.3.1.1 8(2)(a) The health establishment must ensure that there are hand washing facilities in every service area. 13.2.3.1.1.1 Hand washing facilities are available.

Assessment type: Observation - **Risk rating:** Vital measure

Verify whether the hand washing items listed below are available. Score 1 if the item is available and 0 if not available.

Score	Comment

Unit 1 Area 1

Aspects	Score	Comment
1. Functional hand wash basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Taps are functional and not broken. Explanatory Note: Taps must be elbow or non-touch operated in user care areas.		
3. Plain liquid soap		
4. Wall mounted soap dispenser		
5. Paper towel dispenser with disposable hand paper towels.		
6. General waste container. Explanatory note: Containers used for the temporary storage of general waste should be leak proof, intact, corrosive resistant and have a tight-fitting lid. The container must be lined with the appropriate colour coded liner. (Practical Manual: Implementation of the National Infection Prevention and Control Strategic Framework page 82 and page 84).		

Unit 2 Area 2

Aspects	Score	Comment
1. Functional hand wash basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Taps are functional and not broken. Explanatory Note: Taps must be elbow or non-touch operated in user care areas.		
3. Plain liquid soap		
4. Wall mounted soap dispenser		
5. Paper towel dispenser with disposable hand paper towels.		
6. General waste container. Explanatory note: Containers used for the temporary storage of general waste should be leak proof, intact, corrosive resistant and have a tight-fitting lid. The container must be lined with the appropriate colour coded liner. (Practical Manual: Implementation of the National Infection Prevention and Control Strategic Framework page 82 and page 84).		

Unit 3 Area 3

Aspects	Score	Comment
1. Functional hand wash basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Taps are functional and not broken. Explanatory Note: Taps must be elbow or non-touch operated in user care areas.		
3. Plain liquid soap		
4. Wall mounted soap dispenser		
5. Paper towel dispenser with disposable hand paper towels.		
6. General waste container. Explanatory note: Containers used for the temporary storage of general waste should be leak proof, intact, corrosive resistant and have a tight-fitting lid. The container must be lined with the appropriate colour coded liner. (Practical Manual: Implementation of the National Infection Prevention and Control Strategic Framework page 82 and page 84).		

13.2.3.1.1.2 Alcohol based hand rub is available.

Assessment type: Observation - **Risk rating:** Vital measure
Select three areas and observe whether alcohol-based hand rub is available. Score 1 if available and 0 if not available.

Score	Comment

Aspects	Score	Comment
1. Area 1		
2. Area 2		
3. Area 3		

13.2.3.1.1.3 Posters on hand hygiene are displayed.

Assessment type: Observation - **Risk rating:** Essential measure
Select three areas and observe whether posters on hand hygiene are displayed. This could be a single hand hygiene poster or individual posters for hand washing or correct use of alcohol-based hand rub. Score 1 if available and 0 if not available.

Score	Comment

Aspects	Score	Comment
1. Area 1		
2. Area 2		
3. Area 3		

Criterion 13.2.3.1.2 8(2)(b) The health establishment must provide isolation units or cubicles where users with contagious infections can be accommodated.

13.2.3.1.2.1 Isolation room meets the requirements.

Assessment type: Observation - **Risk rating:** Vital measure
Inspect the isolation rooms to verify whether they contain the aspects listed below. Score 1 if the aspect is present and 0 if not present.

Score	Comment

Aspects	Score	Comment
General requirements to be always inspected.		
1. Single room with door that closes. Explanatory note: In the case of an outbreak, multiple users may be accommodated in the same room, as long as the room is used exclusively to care for users with the outbreak disease, i.e., “Cohorting” of patients. Sporadic, individual cases must be nursed in a room that accommodates a single user only.		
2. Rooms used for infections requiring airborne precautions have adequate ventilation. Explanatory note: This will be a minimum of a window that opens, but preferably negative pressure ventilation.		
3. Hand wash basin with elbow-operated taps		
4. Bin with a close-fitting lid		
5. Separate toilet facilities. Explanatory note: This may be a dedicated commode, or urinal and bedpan.		
Requirement to be inspected only if there is a user isolated in the room.		
6. Alcohol based hand rub inside room.		
7. Disinfectant outside of room to disinfect surfaces		
8. Disposable gloves		
9. Bio-hazardous tape for labelling of specimens prior to transporting		
10. Poster/Signs affixed outside the room. Explanatory note: This will include the different types of transmission precautions i.e. airborne, contact or droplet and posters regarding visiting restrictions.		
11. Alcohol based hand rub outside room.		
12. People traffic in and out of room to be controlled (i.e. limited number of visitors and personnel)		
13. Appropriate measures for discarding infected linen.		
14. Appropriate measures for disinfection of equipment		

13.2.3.1.2.2 Terminal cleaning is carried out in isolation rooms.

Assessment type: Document - **Risk rating:** Vital measure
The infection prevention and control link nurse or champion is responsible for ensuring that rooms used for the care of users with infections requiring isolation are adequately cleaned and decontaminated after the user has been moved out of the isolation room. Request documented evidence from the previous three months, this may include but not limited to clearance certificate from the IPC team or checklist for terminal cleaning of isolation rooms completed and signed by the IPC co-ordinator or unit/health facility manager. (Practical Manual for implementation of National IPC Strategic Framework March 2020 page 107).
Not applicable: Never

Score	Comment

Criterion 13.2.3.1.3 8(2)(c) The health establishment must ensure there is clean linen to meet the needs of users.

13.2.3.1.3.1 The unit manager has determined the linen requirements for the unit.

Assessment type: Document - **Risk rating:** Essential measure
It is necessary to determine the linen requirements for the unit, to ensure sufficient linen is available, i.e. the number of linen items required to ensure that all users have clean linen and are warm enough during their admission. It is also necessary to determine how many linen items must be available in the linen storage area for routine linen changes, and to respond to episodes of dirtying or soiling of linen. A document indicating linen requirements for the unit must be available.
Not applicable: Never

Score	Comment

13.2.3.1.3.2 Linen rooms or storage cupboards are adequately stocked and well organised.

Assessment type: Observation - **Risk rating:** Essential measure
Inspect the area where linen is stored to determine whether the aspects listed below are compliant. Score 1 if the aspect is compliant and 0 if not compliant.

Score	Comment

Aspects	Score	Comment
1. Designated area for storage of linen		
2. Linen is stored on shelves.		
3. Area is well organised.		
4. Clean linen is available		

Criterion 13.2.3.1.4 8(2)(d) The health establishment must ensure that health care personnel are protected from acquiring infections through the use of personal protective equipment and prophylactic immunisations.

13.2.3.1.4.1 Personal protective equipment is worn.

Assessment type: Observation - **Risk rating:** Vital measure
Using the checklist below, determine whether protective clothing and equipment is worn in the areas listed. Score 1 if the items are worn and 0 if not worn. Score not applicable where at the time of the inspection health care providers are not in a situation in which they are required to wear protective clothing.

Score	Comment

Unit 1 Area 1

Aspects	Score	Comment
1. Non-sterile or sterile gloves		
2. Disposable gowns or aprons		
3. Protective face shields or goggles		
4. Face masks or N95 or KN95 or FFP2 respirators or approved equivalent		

Unit 2 Area 2

Aspects	Score	Comment
1. Non-sterile or sterile gloves		
2. Disposable gowns or aprons		
3. Protective face shields or goggles		
4. Face masks or N95 or KN95 or FFP2 respirators or approved equivalent		

Unit 3 Cleaner

Aspects	Score	Comment
1. Domestic gloves		
2. Disposable gowns or aprons		
3. Protective face shields or goggles		
4. Face masks or N95 or KN95 or FFP2 respirators or approved equivalent		

Sub Domain 13.2.4 9 Waste management.
Standard 13.2.4.1 9(1) The health establishment must ensure that waste is handled, stored, and disposed of safely in accordance with the law.
Criterion 13.2.4.1.1 9(2)(a) The health establishment must have appropriate waste containers at the point of waste generation.

13.2.4.1.1.1 The unit has appropriate containers for disposal of all types of waste.

Assessment type: Observation - **Risk rating:** Vital measure
Verify whether the waste containers listed below are available. Health care risk waste containers must have the appropriate international hazard symbol and be marked as prescribed in the SANS 10248-1: Management of Health Care Waste, Part 1: Management of health care risk waste from a health facility. Score 1 if the waste container is available and 0 if not available. Where a particular type of waste is not generated in the maternity unit, score not applicable.

Score	Comment

Aspects	Score	Comment
1. Human anatomical waste (red bucket with tight fitting lid)		

2. Infectious non-anatomical waste (red)		
3. Sharps (yellow)		
4. General waste (black, beige, white or transparent packaging may be used)		

Criterion 13.2.4.1.2 9(2)(b) The health establishment must implement procedures for the collection, handling, storage and disposal of waste.

13.2.4.1.2.1 Sharps are safely managed and discarded.

Assessment type: Observation - **Risk rating:** Vital measure
Select three clinical areas and verify whether sharps, needles and the collection of sharps are correctly managed. Score 1 if compliant, score 0 if not compliant.

Score	Comment

Unit 1 Clinical area 1

Aspects	Score	Comment
1. Sharps containers available at site of use		
2. Sharps containers have correctly fitting lids		
3. Needles are not recapped before disposal (not applicable where Safety-engineered devices, i.e. built-in safety devices for recapping or retracting the needle, is used). Explanatory note: This does not apply where it is not possible to see inside the sharps container		
4. Syringes with attached needles are discarded in their entirety		

Unit 2 Clinical area 2

Aspects	Score	Comment
1. Sharps containers available at site of use		
2. Sharps containers have correctly fitting lids		
3. Needles are not recapped before disposal (not applicable where Safety-engineered devices, i.e. built-in safety devices for recapping or retracting the needle, is used). Explanatory note: This does not apply where it is not possible to see inside the sharps container		
4. Syringes with attached needles are discarded in their entirety		

Unit 3 Clinical area 3

Aspects	Score	Comment
1. Sharps containers available at site of use		
2. Sharps containers have correctly fitting lids		
3. Needles are not recapped before disposal (not applicable where safety-engineered devices, i.e. built-in safety devices for recapping or retracting the needle, is used). Explanatory note: This does not apply where it is not possible to see inside the sharps container		

4. Syringes with attached needles are discarded in their entirety		

13.2.4.1.2.2 A register for all anatomical waste is available.

Assessment type: Document - **Risk rating:** Essential measure
A register for documentation of anatomical waste to prevent the loss of placentas /body parts must be available. Entries must be completed in full.
Not applicable: Never

Score	Comment

13.2.4.1.2.3 There is a temporary health care risk waste storage area.

Assessment type: Observation - **Risk rating:** Essential measure
In all areas where waste is held for collection and removal to the central storage area, a designated area for temporary storage of waste must be available. Some health establishments will have a purpose-built temporary waste storage area, others will utilise a specific area within the available space. Score 1 if the aspect is compliant and 0 if not compliant or where there is no designated area.

Score	Comment

Aspects	Score	Comment
1. Space available to store waste containers		
2. Area is well ventilated		
3. Area is well lit		
4. Area has impervious floor surfaces (waterproof or resistant, not cracked)		
5. Refrigeration facility maintained at –2 degrees Celsius. Explanatory note: Score not applicable where the refrigeration facility for waste is not kept in the unit		
6. All waste in the refrigeration facility is appropriately containerised. Explanatory note: Score not applicable where the refrigeration facility for waste is not kept in the unit.		

Sub Domain 13.2.5 21 Adverse events.
Standard 13.2.5.1 21(1) The health establishment must have a system to monitor and report all adverse events.
Criterion 13.2.5.1.1 21(2)(b) The health establishment must have systems in place to report adverse incidents to a structure in the health establishment or responsible authority that monitors these events.

13.2.5.1.1.1 Health care personnel are aware of the procedure to report adverse events.

Assessment type: Staff interview - **Risk rating:** Essential measure
Interview three health care personnel to establish their awareness on reporting of adverse events. Score 1 if they are able to explain the aspects listed below and 0 if not.

Score	Comment

Unit 1 Health care personnel 1

Aspects	Score	Comment
1. Types of adverse events that might happen in the unit (give three examples)		
2. How to report adverse events in the unit		
3. Feedback processes on reported adverse events. Explanatory notes: This could include but not limited to formal feedback on the progress, outcome and quality improvement plans.		

Unit 2 Health care personnel 2

Aspects	Score	Comment
1. Types of adverse events that might happen in the unit (give three examples)		
2. How to report adverse events in the unit		
3. Feedback processes on reported adverse events. Explanatory notes: This could include but not limited to formal feedback on the progress, outcome and quality improvement plans.		

Unit 3 Health care personnel 3

Aspects	Score	Comment
1. Types of adverse events that might happen in the unit (give three examples)		
2. How to report adverse events in the unit		
3. Feedback processes on reported adverse events. Explanatory notes: This could include but not limited to formal feedback on the progress, outcome and quality improvement plans.		

Domain 13.3 CLINICAL SUPPORT SERVICES
Sub Domain 13.3.1 10 Medicines and medical supplies.
Standard 13.3.1.1 10(1) The health establishment must comply with the provisions of the Pharmacy Act, 1974 and the Medicines and Related Substances Act, 1965.
Criterion 13.3.1.1.1 10(2)(a) The health establishment must implement and maintain a stock control system for medicine and medical supplies.

13.3.1.1.1.1 The stock control system shows minimum and maximum levels and/or reorder levels for medicine.

Assessment type: Observation - **Risk rating:** Essential measure
Randomly sample five items held as stock and verify whether minimum, maximum and/or reorder levels are documented. The levels must be recorded on the bin cards or equivalent. The system may be manual or electronic. Score 1 if compliant and 0 if not compliant.

Score	Comment

Aspects	Score	Comment
1. Item 1		
2. Item 2		
3. Item 3		
4. Item 4		

5. Item 5		

13.3.1.1.1.2 Stock levels of medicines on the shelves correspond with recorded stock levels in the stock control system.
Assessment type: Observation - **Risk rating:** Essential measure
Randomly sample five items held as stock and verify the number of items available against the balance indicated on the bin cards or equivalent. The system may be manual or electronic. Score 1 if compliant and 0 if not compliant.

Score	Comment

Aspects	Score	Comment
1. Item 1		
2. Item 2		
3. Item 3		
4. Item 4		
5. Item 5		

13.3.1.1.1.3 The entries in the schedule 5 and 6 drug register are complete.

Assessment type: Document - **Risk rating:** Vital measure
All columns in the registers must be completed comprehensively. Any omitted information noted during the review of the register will receive a non-compliant score. Verify whether all sections of the register have been completed.
Not applicable: Never

Score	Comment

13.3.1.1.1.4 The schedule 5 and 6 medicines in stock correspond with the balance recorded in the register.

Assessment type: Document - **Risk rating:** Vital measure
Randomly sample three medicines from the schedule 5 and 6 medicine cupboard and verify whether the quantity available corresponds with the balance recorded in the register. Score 1 if there is correspondence 0 if not.

Score	Comment

Aspects	Score	Comment
1. Medicine 1		
2. Medicine 2		
3. Medicine 3		

13.3.1.1.1.5 The stock control system shows minimum and maximum levels and/or reorder levels for medical supplies

Assessment type: Observation - **Risk rating:** Essential measure

Randomly sample five items held as stock and verify whether minimum, maximum and/or reorder levels are documented. The levels must be recorded on the bin cards or equivalent. The system may be manual or electronic. Score 1 if compliant and 0 if not compliant.

Score	Comment

Aspects	Score	Comment
1. Item 1		
2. Item 2		
3. Item 3		
4. Item 4		
5. Item 5		

13.3.1.1.1.6 Physical stock of medical supplies corresponds with stock control system.

Assessment type: Observation - **Risk rating:** Essential measure

Randomly sample five items held as stock and verify whether their items availability corresponds with the balance indicated on the bin cards or equivalent. The system may be manual or electronic. Score 1 if there is correspondence and 0 if not.

Score	Comment

Aspects	Score	Comment
1. Item 1		
2. Item 2		
3. Item 3		
4. Item 4		
5. Item 5		

Criterion 13.3.1.1.2 10(2)(b) The health establishment must ensure the availability of medicines and medical supplies for the delivery of services.

13.3.1.1.2.1 Basic medical supplies (consumables) are available.

Assessment type: Observation - **Risk rating:** Vital measure

Request the list of medical supplies/consumables for the unit and randomly sample five items from each of the categories listed below and check whether the selected items are available and not expired (where applicable). Document the name of the non-compliant items that were sampled. Score 1 if the sampled item is available and not expired (where applicable) or 0 if not available or expired or if there is no list of medical supplies/consumables available.

Score	Comment

Aspects	Score	Comment

Surgical supplies		
1. Item 1		
2. Item 2		
3. Item 3		
4. Item 4		
5. Item 5		
Dressing supplies		
6. Item 1		
7. Item 2		
8. Item 3		
9. Item 4		
10. Item 5		
Laboratory supplies		
11. Item 1		
12. Item 2		
13. Item 3		
14. Item 4		
15. Item 5		
Other supplies		
16. Item 1		
17. Item 2		
18. Item 3		
19. Item 4		
20. Item 5		

Sub Domain 13.3.3 12 Blood services.

Standard 13.3.3.1 12(1) Hospitals and CHCs must ensure that users have access to blood and blood products when required.

Criterion 13.3.3.1.1 12(2)(c) The health establishment must ensure that adverse blood reactions are reported to a committee in the health establishment that monitor adverse incidents.

13.3.3.1.1.1 All adverse blood reactions are reported to relevant forum.

Assessment type: Document - **Risk rating:** Vital measure

Manual or electronic minutes from the previous quarter must reflect that the forum has been informed of all adverse blood reactions and that the forum has considered and discussed the reported incidents. If no incidents were reported, zero reporting must be done.
Not applicable: Where no adverse blood reactions have occurred and there is evidence of zero reporting.

Score	Comment

13.3.3.1.1.2 Corrective action is taken where adverse blood reactions were reported.

Assessment type: Document - **Risk rating:** Vital measure
Documented evidence of the corrective actions taken to prevent adverse blood reactions. If no incidents occurred in the previous quarter, zero reporting must be done.
Not applicable: Where no adverse blood reactions were reported.

Score	Comment

Sub Domain 13.3.2 13 Medical equipment.
Standard 13.3.2.1 13(1) Health establishments must ensure that the medical equipment is available and functional in compliance with the law.
Criterion 13.3.2.1.1 13(2)(b) The health establishment must ensure that equipment is in accordance with the essential equipment list in all clinical service areas.

13.3.2.1.1.1 Functional essential equipment is available in the unit.

Assessment type: Observation - **Risk rating:** Vital measure
Request the list of medical equipment for the unit, randomly sample ten different items and check whether the sampled equipment is available and functional. Document the name of the non-compliant equipment that was sampled. Score 1 if the selected item is available and functional or 0 if not available or not functional or if the list is not available.

Score	Comment

Aspects	Score	Comment
1. Equipment 1		
2. Equipment 2		
3. Equipment 3		
4. Equipment 4		
5. Equipment 5		
6. Equipment 6		
7. Equipment 7		
8. Equipment 8		
9. Equipment 9		
10. Equipment 10		

Domain 13.4 GOVERNANCE AND HUMAN RESOURCES

Sub Domain 13.4.1 20 Occupational health and safety.

Standard 13.4.1.1 20(1) The health establishment must comply with the requirements of the Occupational Health and Safety Act, 1993.

Criterion 13.4.1.1.1 20 The health establishment must have a disaster management plan in place, which is communicated to health care personnel and tested annually.

13.4.1.1.1.1 The action to be taken when the disaster management response is activated is visibly displayed.

Assessment type: Observation - **Risk rating:** Essential measure

The action to be taken by allocated individuals in the event of a disaster must be clearly visible for easy reference during a disaster. This may be displayed in any manner relevant to the size and complexity of the health establishment, including, but not limited to, a single summary sheet of actions to be taken, action cards to be retrieved by allocated individuals to remind them of the tasks for which they are responsible, or any other method chosen by the health establishment.

Not applicable: Never

Score	Comment

Domain 13.5 FACILITIES AND INFRASTRUCTURE

Sub Domain 13.5.1 15 Engineering services.

Standard 13.5.1.1 15(1) The health establishment must ensure that engineering services are in place.

Criterion 13.5.1.1.1 15(2) The health establishment must have 24-hour electrical power, lighting, medical gas, water supply and sewerage disposal system.

13.5.1.1.1.1 Piped oxygen or oxygen cylinders is available in the unit.

Assessment type: Observation - **Risk rating:** Non-negotiable measure

This is to ensure that users have access to oxygen when required. Verify whether piped oxygen or oxygen cylinders are available and functional in the unit.

Not applicable: Never

Score	Comment

13.5.1.1.1.2 Piped or portable suction is available in the unit.

Assessment type: Observation - **Risk rating:** Vital measure

This is to ensure that users have access to suction when required. Verify whether piped or portable suction is available and functional in the unit.

Not applicable: Never

Score	Comment

Official Sign-Off

The National Health Act, 2003 (Act No. 61 of 2003) provides for quality requirements and standards in respect of health services provided by health establishments to the public. The main objective is to promote and protect the health and safety of the users of health services and contribute to improved outcomes and improved population health.
To achieve this mandate standardised inspection tools aligned to Norms and Standards Regulations applicable to different categories of health establishments promulgated by the Minister of Health in 2018 have been developed for District Hospitals.

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It is hereby certified that the Regulatory District Hospital Inspection tools version 1.4 was updated by the Office of Health Standards Compliance.

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