UNITED NATIONS MANUAL
on
Healthcare Quality and Patient Safety

Level 1 Clinics

Preface

A. General

The United Nations (UN) is committed to providing a consistent level of high quality care to all mission personnel, regardless of the country, situation or environment in which they receive medical treatment.

Standards and accreditation are a core pillar of modern healthcare management. In the absence of standards, the quality of care delivered is "luck of the draw". The duration of UN operations means that our hospital facilities are more likely to be fixed facilities, and less likely to be true "field" hospitals. There is hence a need to ensure that the UN health care system implements best-practice methods to standardize and improve the quality of healthcare.

Troop Contributing Countries (TCC), Police Contributing Countries (PCC) and commercial vendors have their own health care standards, processes, and systems that are customary and acceptable and most likely, subject to regulation and oversight in their home countries. It does not automatically follow that these same standards will be faithfully implemented in the peacekeeping environment, where domestic or even host-country regulators have no jurisdiction, and both operations and oversight face the challenges of distance and diversity.

Recognizing the central importance of standards, and to reduce ambiguity regarding which standards are applicable in UN settings, the Division of Health Management and Occupational Safety and Health (DHMOSH), developed standards for health care quality management and patient safety applicable to all UN healthcare facilities. Many national and international standard regimens were reviewed, and Joint Commission International (JCI) standards were consequently adopted as the basis for development of customized UN standards[1]. Through these standards, the mission of DHMOSH is to improve the safety and quality of care in the UN healthcare facilities through the provision of education, publications, consultation, and evaluation services.

Expected outcomes of implementing UN health care standards include the following:

- Reduce preventable harm and reduce morbidity and mortality;
- Provide consistency and reliability in processes and systems in all UN Hospitals and Clinics;
- Meet expectations of all mission and UN personnel for trustworthy, consistent and dependable care;
- Create the ability to collect and measure clinical outcomes for quality improvement; and
- Create the ability to measure patient experience.

[1] Customized Documentation based on JCI Standards in the *United Nations Manual for Health Care Quality and Patient Safety for Clinics*, is used therein with permission from JCI.

B. Structure of the manual

This manual comprises of three sections: UN International Patient Safety Goals, Clinical focused standards and Administration focused standards.
These standards have been compiled in 3 (three) manuals, the *United Nations Manual for Health Care Quality and Patient Safety for Hospitals,* the *United Nations Manual for Health Care Quality and Patient Safety for UN Clinics, and the United Nations Manual for Health Care Quality and Patient Safety for UN Referral Hospitals*

C. Relationship to other official documents

The contents of this manual are compatible with the rules and regulations of the United Nations administrative issuance, official United Nations guidelines and other documents relevant to the administration of United Nations field operations such as the Medical Support Manual. References are made in the manual to the relevant documents when compliance with a standard is expected. The chapter on Surgical and Anaesthesia safety and Hand hygiene, for example, reference the WHO guidelines. The hope is that this manual will create uniformity in the delivery of medical services in all the medical facilities of the United Nations.

D. Distribution and revision

The Medical Director, Division of Healthcare Management and Occupational Health and Safety, controls the distribution of this manual. The manual will be updated and distributed every three years.

E. Acknowledgements

The Department of Operational Support/Division of health care Management and Occupational Health and Safety would like to thank Joint Commission International for their support in offering to the United Nations their standards and allowing the UN to adapt these standards to meet the field conditions. The following individuals worked on this document to bring it to fruition:
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Introduction

These standards will be required for compliance in all clinics in Peacekeeping Missions according to an implementation timeline set by Medical Services Division/Medical Director. **To facilitate the implementation, the most critical standards are defined as CORE standards and are marked with a red colored headline. CORE standards are expected to be implemented immediately by every Level 1 clinic.** The black headlined standards are supplementary and are a next level priority during the implementation process.

The Manual is comprised of three sections:

- Section I, International Patient Safety Goals, originally published by Joint Commission International (JCI), adapted and renumbered in this Manual,
- Section II, Clinical-Focused Standards, Chapters 1-6, and
- Section III, Administration-Focused Standards, Chapters 7-13.

Section I UN International Patient Safety Goals (UNC-IPSG)

Goal 1: Patient Identification

Standard UNC-IPSG.1

The clinic develops and implements a process to improve accuracy of patient identification.

Intent of UNC-IPSG.1

The identification process used in the clinic requires at least two ways in which to identify a patient, such as the patient's name and birth date.

Two different patient identifiers are required in any circumstance involving patient interventions. These include: before administering medications, blood or blood products; before taking blood and other specimens for clinical testing; and before performing procedures and treatments.

Measurable Elements of UNC-IPSG.1

1. Patients are identified using the minimum (mandatory) of patient's name and date of birth.
2. Patients are identified before providing treatments and procedures.
3. Patients are identified before any diagnostic procedures.

Goal 2: Improve Effective Communication

Standard UNC-IPSG.2

The clinic develops and implements a process to ensure that all orders are written.

Standard UNC-IPSG.2.1

The clinic develops and implements a process for reporting critical results of diagnostic tests.

Standard UNC-IPSG.2.2

The clinic develops and implements a process for handover communication.

Intent of UNC-IPSG.2 through UNC-IPSG.2.2

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, or written, or in emergency situations, verbal. Patient care circumstances that can be critically impacted by poor communication include patient care orders, communication of critical test results, and hand-over communications. For example, drug names and numbers which sound alike, such as erythromycin instead of azithromycin, or fifteen instead of fifty, can affect the accuracy of the order.

The reporting of critical results of diagnostic tests is also a patient safety issue. Results that are significantly outside the normal range may indicate a high-risk or life-threatening condition.

Measurable Elements of UNC-IPSG.2

1. The complete physician order is documented in the medical record or, if available, in the electronic health record.

2. When a verbal order is unavoidable, the order is documented on a UN approved form, read back to the ordering physician, and signed by the ordering physician within 24 hours.

Measurable Elements of UNC-IPSG.2.1

1. The clinic has defined critical values for each type of diagnostic test.

2. The clinic has identified how, by whom, and to whom critical results of diagnostic tests are reported.

3. The clinic has identified what information is documented in the patient record.

Measurable Elements of UNC-IPSG.2.2

1. Standardized critical content is communicated between healthcare providers during handovers of patient care utilizing the UN approved IPASS methodology (See Annex A).

2. The content of the medical record is available to all those caring for a patient, and the content is standardized, including the use of any abbreviations, signs, and symbols, and for medication changes.

3. There is a process to periodically review a sample of patient records, and this information is used to improve completeness, legibility, and accuracy of the content of all patient records.

Goal 3: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery

Standard UNC-IPSG.3

The clinic implements a process for ensuring correct-site, correct-procedure, and correct-patient surgery, if any kind of a surgical intervention is performed.

Standard UNC-IPSG.3.1

The clinic implements a process for Time Out that is performed immediately prior to the start of surgery to ensure correct-site, correct-procedure, and correct-patient surgery.

Intent of UNC-IPSG.3 and UNC-IPSG.3.1

Wrong-site, wrong-procedure, wrong-patient surgery is an alarmingly common occurrence in clinics. These errors are the result of ineffective or inadequate communication between members of the surgical team, lack of patient involvement in site marking, and lack of procedures for verifying the operative site.

Surgery and invasive procedures include all procedures that investigate and/or treat diseases and disorders of the human body through cutting, removing, altering, or insertion of diagnostic/therapeutic scopes. Evidence-based practices are described in the WHO Surgical Safety Checklist. The essential processes are:

- marking the surgical site;
- a preoperative verification process; and
- a time-out that is held immediately before the start of a procedure.

Marking the surgical and invasive procedure site involves the patient and is done with an instantly recognizable mark. The mark must be by the person performing the procedure; should take place with the patient awake and aware, if possible; and must be visible after the patient is prepped and draped. The surgical site is marked in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine).

The purpose of the preoperative verification process is to:

- verify the correct site, procedure, and patient;
- ensure that all relevant documents, images, and studies are available, properly labeled, and displayed.

The time-out is conducted in the location at which the procedure will be done, just before starting the procedure, and involves the entire operative team. When possible, the patient will participate in the time out procedure to ensure correct site, correct procedure and correct patient prior to sedation.

Measurable Elements of UNC-IPSG.3

1. The clinic uses an instantly recognizable mark for surgical and invasive procedure site identification that is consistent throughout the clinic.
2. Surgical and invasive procedure site marking is done by the person performing the procedure and, when possible, involves the patient in the marking process.

Measurable Elements of UNC-IPSG.3.1

1. The clinic conducts and documents a Time Out procedure in the area in which the surgery/invasive procedure will be performed, just before starting the surgical/invasive procedure.
2. The components of the Time Out include correct patient identification, correct site and side, agreement of the procedure to be done, and confirmation that the verification process has been completed.
3. When procedures are performed, including medical and dental procedures done in settings other than the operating theatre, the clinic uses uniform processes to ensure the correct site, correct procedure, and correct patient.

Goal 4: Reduce the Risk of Health Care-Associated Infections

Standard UNC-IPSG-4

The clinic adopts and implements WHO Guidelines for Hand Hygiene in Health Care to reduce the risk of health care–associated infections.

Intent of UNC-IPSG.4

Infection prevention and control are challenging in most health care settings, and rising rates of healthcare associated infections are a major concern for patients and health care practitioners.

Central to the elimination of infections is proper hand hygiene. Internationally acceptable hand hygiene guidelines are available from the World Health Organization (WHO). Hand hygiene guidelines and information materials are posted in appropriate areas, and staff members are educated in proper hand washing and hand disinfection procedures. Soap, disinfectants, and towels or other means of drying are located in those areas where hand-washing and hand-disinfecting procedures are required.

Measurable Elements of UNC-IPSG.4

1. The clinic uses and follows the current WHO Guidelines for Hand Hygiene in Health Care.
2. The clinic has a written policy for implementing an effective hand hygiene program throughout the entire facility.
3. Hand washing and hand disinfection procedures are used in accordance with hand-hygiene guidelines and information materials throughout the clinic.

Section II Clinical Focused Standards

Chapter 1 - Access to Care (UNC-AC)

Standard UNC-AC.1

The clinic has a process for registering outpatients.

Intent of UNC-AC.1

The process for registering outpatients for services is standardized. Staff members are familiar with and follow the standardized process defined by the UN.

The process addresses:

- registration for outpatient services,
- holding patients for observation.

Measurable Elements of UNC-AC.1

1. The clinic follows the UN standardized outpatient registration process.
2. The clinic has a standardized process for holding patients for observation.
3. Staff members are familiar with and follow the registration and holding processes.

Standard UNC-AC.2

The clinic develops and implements a process to refer patients to other healthcare settings to meet their continuing care needs.

Intent of UNC-AC.2

It is critical for patients with emergency needs to receive care in the most effective healthcare setting. The process for referring patients with emergency needs is standardized in order to ensure next steps are in place.

Measurable Elements of UNC-AC.2

1. There is an organized process for referring patients.
2. The clinic refers patients when it is unable to meet patients' continuing care needs. The referral ensures the availability of services to meet patients' continuing care needs.

Standard UNC-AC.3

Patient follow up instructions are given in a form and language the patient can understand.

Intent of UNC-AC.3

The Level 1 Clinic provides the instructions to the patient in a simple, understandable manner. The instructions are provided in writing or in the form most understandable to the patient when the patient is not able to understand written instructions.

Measurable Elements of UNC-AC.3

1. Patient follow up instructions are provided in writing and in a form and language that the patient can understand.
2. The instructions include any return for follow-up care.
3. The instructions include when to obtain urgent care.

Standard UNC-AC.4

The process for referring or transferring the patient evaluates the need for transportation.

Intent of UNC-AC.4

The transportation needs of the patient are evaluated when care is complete or when the patient is referred to another source of care. Assessing the patient's transportation needs and ensuring that the patient has safe transportation to return home or to a higher level of care is the organization's responsibility. On occasion, a patient may arrive at the clinic in an emergency condition or may deteriorate to a condition that requires immediate clinical care at a level that is beyond the scope of the clinic. The clinic ensures safe transportation of these patients in a timely manner to a hospital that can provide the appropriate level of care.

Measurable Elements of UNC-AC.4

1. The process for referring patients evaluates the need for transportation.
2. The process for transferring patients evaluates the need for transportation.
3. When a patient is identified with emergency clinical care needs that are beyond the scope and mission of the clinic, the clinic ensures safe and timely transportation to a healthcare organization that can provide the appropriate level of care.

Chapter 2 - Continuity of Care (UNC-CC)

Standard UNC-CC.1

The clinic has processes to provide continuity of patient care services in the clinic and coordination among health care practitioners.

Intent of UNC-CC.1

Continuity is enhanced when all patient care providers have the information needed from the patient's current and past medical experiences to help in decision making.

The patient's record is a primary source of information on the patient's care and progress and is an essential communication tool. For this information to be useful and to support the continuity of the patient's care, the patient record needs to be available during outpatient visits and is kept up to date. Medical, nursing, and other patient care notes are available to all the patient's health care practitioners who need them in order to care for the patient.

Measurable Elements of UNC-CC.1

1. The patient's record is available to those practitioners who are authorized to have access and need it for the care of the patient.
2. The patient's record is up to date.
3. Continuity and coordination are evident throughout all phases of patient care.

Standard UNC-CC.2

There is a process for the referral of patients that is based on the patient's health status and the need for continuing care or services.

Intent of UNC-CC.2

Referring a patient to a health care practitioner outside the clinic is based on the patient's health status and need for continuing care or services. An organized process is required to ensure that any continuing needs are met by appropriate health care practitioners or the receiving clinic or hospital.

Measurable Elements of UNC-CC.2

1. Patients are referred based on their health status and needs for continuing care.
2. The clinic uses a standardized patient referral form.

Standard UNC-CC.3

Patient education and instruction are related to the patient's continuing care needs.

Intent of UNC-CC.3

The clinic routinely provides education in a language and method patients understand, on topics that carry high risk to patients. The clinic uses standardized materials and processes in educating patients on at least the following topics, as applicable:

- Safe and effective use of all medications taken by the patient, including potential medication side effects,
- Safe and effective use of medical technology used by or near the patient,
- Potential interactions between prescribed medications, other medications (including over-the-counter preparations) and food,
- Diet and nutrition,
- Pain management, and
- Rehabilitation techniques.

Measurable Elements of UNC-CC.3

1. Patients are educated in a language and method they understand about the safe and effective use of all medications, potential side effects, and prevention of potential interactions with over-the-counter medications and/or food.
2. Patients are educated about proper diet and nutrition for their current condition.
3. Patients are educated about pain management, as appropriate.
4. Patients are educated about rehabilitation techniques, as appropriate.
5. Patients confirm their understanding of the education received and this is documented in the patient record.

Standard UNC-CC.4

The clinic has a process for the management and follow-up of patients who notify clinic staff that they intend to leave against medical advice.

Intent of UNC-CC.4

When a patient decides to leave the clinic before an examination has been completed and a treatment plan recommended this is identified as "leaving against medical advice." Patients have the right to refuse medical treatment, however these patients may be at risk, which may result in permanent harm or death. When a patient requests to leave the clinic without medical approval, the medical risks must be explained by the health care professional providing the treatment plan or his or her designee. Efforts should be made to identify the reason the patient is choosing to leave against medical advice. Clinics need to understand these reasons to be able to provide better communication to patients and/or families and identify potential process improvements.

Measurable Elements of UNC-CC.4

1. The process for managing patients who notify staff that they are leaving against medical advice is followed.
2. The process includes informing the patient of the medical risks of inadequate treatment.
3. The patient should be discharged by signing the UN approved form or in Earthmed.
4. The clinic has a process to try to identify the reasons for patients leaving against medical advice.
5. The process is consistent with applicable rules and regulations, including requirements for reporting cases of infectious disease and cases in which patients may be a threat to themselves or others.

Standard UNC-CC.5

The clinic has a process for the management of patients who leave the clinic against medical advice without notifying clinic staff.

Intent of UNC-CC.5

When a patient leaves the clinic against medical advice without notifying anyone or is receiving complex or lifesaving treatment and does not return for treatment, the clinic must make reasonable efforts to contact the patient to inform him or her of potential risks.

When applicable, the clinic reports cases of infectious disease and provides information regarding patients who may harm themselves or others to local health authorities, the CMO (if appropriate) and the UN Medical Director.

Measurable Elements of UNC-CC.5

1. The process for the management of patients who leave the clinic against medical advice without notifying clinic staff is followed.

2. The process for the management of patients receiving complex treatment who do not return for treatment is followed.

3. The process is consistent with applicable UN regulations, including requirements for reporting cases of infectious disease and cases in which patients may be a threat to themselves or others.

Medevac of Patients

Standard UNC-CC.6

Patients are medevaced to the next level of care based on their medical status, and the ability of the receiving organization to meet patients' needs.

Intent of UNC-CC.6

Medevacing a patient to a hospital is based on the patient's status and need for continuing health care services. Medevac may be in response to a patient's need for specialized consultation and treatment, urgent services, or less-intensive services such as subacute care. Criteria help to identify when a transfer is necessary to ensure that the patient's needs are met.

When referring a patient, the referring clinic must determine if the receiving hospital provides services to meet the patient's needs and has the capacity to receive the patient. This determination is usually made well in advance, and the willingness to receive patients and the medevac conditions are described in formal or informal affiliations or agreements through a Memorandum of Understanding between the UN and the Clinic. This advance determination ensures continuity of care and that the patient's care needs will be met. Transfers may occur to other providers of specialized treatment or services without formal or informal transfer agreements.

Measurable Elements of UNC-CC.6

1. The need to medevac patients is based on criteria developed by the clinic to address patients' needs for continuing care.

2. Prior to approving the medevac of a patient, the referring physician if applicable (through the CMO, or designee) will consult with the receiving hospital or to confirm if the patient's needs can be met.

3. Formal or informal arrangements are in place with receiving organizations when patients are frequently transferred to the same hospital.

Standard UNC-CC.7

The referring clinic follows the local procedure and (if applicable, UN procedures for the medevac of patients as described in the current Medical Support Manual (MSM)) to ensure that patients are transferred safely.

Intent of UNC-CC.7

The medevac of a patient directly to another health care facility may be a brief process with an alert and talking patient, or it may involve moving an unconscious patient who needs continuous nursing or medical oversight. Thus, the condition and status of the patient determine the qualifications of the staff member monitoring the patient and the type of medical technology needed during medevac.

A consistent process for how patients are transferred from one medical facility to another is important to ensure that patients are transferred safely. Such a process addresses:

- how responsibility is transferred between practitioners and settings;
- criteria for when transfer is necessary to meet the patient's needs;
- who is responsible for the patient during transfer;
- what medications, supplies, and medical technology are required during transfer;
- a follow-up mechanism that provides the condition of the patient during transfer and upon arrival to the receiving organization; and
- what is done when transfer to another source of care is not possible.

The clinic evaluates the quality and safety of the transfer process to ensure that patients are transferred with qualified staff and the correct medical technology for the patient's condition.

Measurable Elements of UNC-CC.7

1. The clinic follows the process mandated by the clinic for continuing care when a patient is moved to another hospital, and uses the UN Form (or a standardized form) for Requesting Medevac to initiate this process.
2. The medevac process identifies who is responsible for monitoring the patient during transfer and the staff qualifications required for the type of patient being transferred.
3. The medevac process identifies the medications, supplies, and medical technology required during transport.
4. The medevac process addresses a follow-up mechanism that provides information about the patient's condition upon arrival, and what information is reported back from the receiving hospital.

Standard UNC-CC.8

The receiving hospital is given a written summary of the patient's clinical condition and the interventions provided by the referring clinic.

Intent of UNC-CC.8

To ensure continuity of care, patient information is transferred with the patient. A copy of necessary clinical records is provided to the receiving hospital with the patient. Another copy is kept in the referring clinic.

Measurable Elements of UNC-CC.8

1. A patient clinical summary document is transferred with the patient.
2. The clinical summary includes patient status.
3. The clinical summary includes procedures and other interventions provided.
4. The clinical summary includes the patient's continuing care needs.
5. When appropriate, a copy of the entire clinical record is transferred with the patient along with their personal identification documents (passport, etc.).

Standard UNC-CC.9

The medevac process is documented in the patient's record.

Intent of UNC-CC.9

The medical record of each patient transferred to another healthcare facility contains all necessary documentation (as required by UN policy). This includes the name of the hospital and the name of the individual agreeing to receive the patient, the reason(s) for the medevac, and any special conditions for medevac. It is noted if the patient's condition or status changed during transfer (for example, the patient dies or requires resuscitation).

Measurable Elements of UNC-CC.9

1. The records of medevac patients note the name of the receiving healthcare organization and the name of the individual agreeing to receive the patient.
2. The records of medevac patients contain documentation or other notes (as required by the policy of the UN).
3. The records of medevac patients note the reason(s) for transfer.
4. The records of medevac patients note any special conditions related to transfer.

Chapter 3 - Assessment of Patients (UNC-AP)

Standard UNC-AP.1

An initial assessment process is used to identify the healthcare needs of all patients.

Intent of UNC-AP.1

An effective patient assessment process is consistent based on patient needs and results in a complete and timely plan to deliver care. The needs of the patient may be related to an acute illness or a chronic condition. Some patients may need specialty services such as minor surgery, endoscopy, dental, ophthalmology, or radiotherapy. The clinic establishes protocols to define and guide an effective and consistent initial assessment process for all patients. The organization identifies who can perform which assessments, such as physicians, nurses, and other clinical disciplines, and defines the initial assessment process for those patients whose needs do not match the organization's mission and resources and who may require a referral or transfer to another organization.

Measurable Elements of UNC-AP.1

1. The clinic develops and implements an initial assessment process to identify the health care needs of all patients.
2. The clinic identifies who performs which assessments.
3. The clinic identifies the assessment process for those patients whose needs do not match the organization's mission and resources and who require a referral or transfer to another organization. The scope and content of initial assessments conducted by different clinical disciplines is defined in writing.

Standard UNC-AP.2

Each patient's initial assessment includes an evaluation of physical, psychological, and social factors, including a physical examination and health history.

Intent of UNC-AP.2

Clinics assess and treat many types of patients. The scope and content of the initial assessment for each type of patient is defined in writing. Thus, the initial assessment for a patient seeking medical care will include obtaining the patient's physical and psychosocial status and health history, with a focus on the patient's condition, presenting problem, accident, injury, or illness.

Similarly, the initial assessment of a dental patient will gather his or her general medical history information while focusing on the reason for the dental visit and any complaint. The scope and content of the initial assessment may be defined in a protocol, or may be identified on assessment forms. When forms are used, it is clear what information must be obtained and recorded for the form to be deemed complete. Assessments are performed by each discipline within its scope of practice, licensure, applicable laws and regulations, or certification. Only qualified individuals conduct the assessments.

The initial assessment of certain types of patients or certain patient populations requires that the assessment process be modified. Such modification is based on the unique characteristics or needs of each patient population. Each clinic identifies those special patient groups and populations and modifies the assessment process to meet their special needs. In particular, when the clinic serves one or more of the special-needs patients or populations listed below (or others the clinic may identify), the clinic conducts individualized assessments:

- Patients with intense or chronic pain
- Women experiencing terminations in pregnancy
- Patients with emotional or psychiatric disorders
- Patients who may have a drug and/or alcohol dependency
- Patients with infectious or communicable diseases
- Patients whose immune systems are compromised
- Pediatric patients

Measurable Elements of UNC-AP.2

1. The scope and content of initial assessments conducted by each clinical discipline are defined in writing.
2. Only qualified individuals permitted by licensure, applicable laws and regulations, or certification perform the assessments.
3. The organization identifies, in writing, those special patient groups and populations it serves that require modifications to its assessment.
4. The assessment process for special patient groups and populations is modified to reflect their needs.

Standard UNC-AP.3

All outpatients are screened for pain and assessed when pain is present.

Intent of UNC-AP.3

During the initial assessment and during any reassessments, a screening procedure is used to identify patients with pain.

Positive answers to questions regarding the presence of pain indicate the need for a more in-depth assessment of the patient's pain. When pain is identified, the patient may be more thoroughly assessed and treated in the clinic or provided with a referral for further assessment and treatment in another healthcare setting.

Measurable Elements of UNC-AP.3

1. Patients are screened for pain.

2. When pain is identified from the initial screening exam, a comprehensive assessment of the patient's pain is performed and the patient is treated as needed in the clinic or provided with a referral for further assessment and treatment. For the UN clinics the process to be used as described in the MSM, Pg. 61, OPQRST[2]

3. The assessment or referral is documented in the patient record.

Standard UNC-AP.4

There is an established reassessment process for patients requiring additional services or ongoing care.

Intent of UNC-AP.4

The clinic may see a patient for an acute illness, a chronic condition, or for specialty services such as surgery, endoscopy, dental, ophthalmology, or radiotherapy. Visits may be one time or ongoing. Patients who are provided additional or continuing services should have their needs reassessed through an established process that identifies the scope and content of the reassessment and who is permitted to conduct the reassessments.

Measurable Elements of UNC-AP.4

1. The scope and content of reassessments conducted by each clinical discipline are documented in the patient record.

2. Only qualified individuals permitted by licensure or certification perform the assessments.

3. The reassessment process for special patient groups and populations is modified to reflect their needs.

Laboratory Services

Standard UNC-AP.5

Laboratory services are available to meet patient needs.

Intent of UNC-AP.5

The clinic has a system for providing laboratory services.

Measurable Elements of UNC-AP.5

1. Laboratory services are readily available on site or through outside sources.

2. Laboratory services on site meet applicable local and national standards, laws, and regulations.

3. Laboratory services provided by outside sources meet applicable standards, laws, regulations, quality expectations, requirements of their contractual arrangements, and professional standards.

[2] Medical Support Manual for United Nations Field Missions, Chapter 4, Annex C, Pg. 61, J, OPQRST

4. Laboratory results are available in a timely manner to the patient's practitioner, as defined by the organization.

5. Laboratory results are available in a timely manner to the patient, as defined by the organization.

6. The organization defines the extent to which the test results are used in an individual's care (for example, diagnostic or as a screen only).

Standard UNC-AP.6

A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.

Intent of UNC-AP.6

Clinical laboratory services are under the direction of an individual who is qualified by documented training, expertise, and experience, consistent with UN standards. This individual assumes professional responsibility for the laboratory facility and the services provided in the laboratory. When this individual provides clinical consultation or medical opinion, he or she is a physician. Responsibilities of the laboratory leader include:

- developing, implementing, and maintaining policies and procedures;
- administrative oversight;
- maintaining a quality control program; and
- monitoring and reviewing all laboratory services.

Measurable Elements of UNC-AP.6

1. The clinical laboratory in the clinic is under the direction and oversight of one or more qualified individuals.

2. Responsibilities for developing, implementing, and maintaining SOPs are defined and carried out.

3. Responsibilities for administrative oversight are defined and carried out.

4. Responsibilities for maintaining quality control programs are defined and carried out.

5. Responsibilities for monitoring and reviewing all laboratory services within and outside the laboratory are defined and carried out.

Standard UNC-AP.7

All laboratory staff members have the required education, training, qualifications, and experience to administer and perform laboratory tests and interpret the results.

Intent of UNC-AP.7

The United Nations identifies the education, training, qualifications, and required experience of laboratory staff members performing and interpreting laboratory tests, and those who direct or supervise staff who perform testing. Technical staff members are given work assignments consistent with their training and experience.

Measurable Elements of UNC-AP.7

1. All laboratory staff members have the required credentials to administer, perform, and interpret tests.

2. Laboratory supervisory staff members are identified and have the proper qualifications and experience.

Standard UNC-AP.8

A laboratory safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.

Intent of UNC-AP.8

The laboratory has an active safety program to the degree required by the risks and hazards encountered in the laboratory. The program addresses safety practices and prevention measures (for example, eye-wash stations, spill kits, and the like) for laboratory staff, other staff, and patients when present. The laboratory program is coordinated with the clinic's facility management and infection control programs.

The laboratory safety management program includes

- compliance with standards addressing facility management and infection control programs;

- availability of safety devices appropriate to the laboratory's practices and hazards encountered;

- the orientation of all laboratory staff to safety procedures and practices; and

- in-service education for new procedures and newly acquired or recognized hazardous materials.

Measurable Elements of UNC-AP.8

1. The laboratory program is part of the clinic's facility management and infection control programs. Staff report when any safety event occurs and a record of this report is kept on file.

2. Laboratory staff members are oriented to safety procedures and practices and receive ongoing education and training for new practices and procedures.

Standard UNC-AP.9

The laboratory uses a coordinated process to reduce the risks of infection because of exposure to biohazardous materials and waste (If UN clinic).

Intent of UNC-AP.9

UN policies, procedures, and practices are implemented to reduce the hazards of exposure to bio-hazardous materials. Infections acquired in the laboratory are reported internally and to the UN Medical Director. The following biosafety hazards and practices are addressed in written procedures, and the requirements of the procedures are followed:

1. Exposures to aerosols and droplets are controlled (for example, when mixing, sonicating, centrifuging, and flaming inoculating loops).

2. Laboratory coats, gowns, or uniforms are worn to protect street clothes and prevent contamination.

3. Biosafety cabinets are used when required.

4. SOPs govern how to handle laboratory exposure to infectious agents, accidental cuts, needlestick injuries, accidental ingestion, and contact of potentially infectious agents with mucus membranes. These SOPs include decontamination procedures, whom to contact for emergency treatment, and the location and use of safety equipment.

5. There are written procedures defining safe collection, transport, and handling of all specimens. The procedure includes prohibiting anyone in laboratory technical areas from eating, drinking, smoking, applying cosmetics, manipulating contact lenses, and mouth pipetting.

6. When relevant to their jobs, personnel have received training about precautionary measures, modes of transmission, and prevention of blood-borne pathogens.

7. When problems with practice are identified, or accidents occur, corrective actions are taken, documented, and reviewed.

Measurable Elements of UNC-AP.9

1. The laboratory has a defined SOP for reducing the risks of infection.

2. Infections acquired in the laboratory are reported.

3. The laboratory follows biosafety rules for relevant practices addressed in elements 1-7 in the Intent Statement.

4. When problems with practice are identified or accidents occur, corrective actions are taken, documented, and reviewed.

Standard UNC-AP.10

All equipment and medical technology used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

Intent of UNC-AP.10

Laboratory staff members work to ensure that all equipment and medical technology, including medical devices used for point-of-care testing, function at acceptable levels and in a manner that is safe to the operator(s). The laboratory develops and implements a program to manage equipment and medical technology that provides for:

- selecting and acquiring laboratory equipment and medical technology as per COE manual (if UN clinic) ;
- identifying and taking inventory of laboratory equipment and medical technology;
- assessing laboratory equipment and medical technology use through inspection, testing, calibration, and maintenance;
- monitoring and acting on laboratory equipment and medical technology hazard notices, reportable incidents, problems, and failures; and
- documenting the management program.

Testing, maintenance, and calibration frequency are related to the laboratory's use of its equipment and medical technology and its documented history of service.

Measurable Elements of UNC-AP.10

1. The laboratory develops, implements, and documents a program to manage laboratory equipment and medical technology.
2. There is a documented inventory of all laboratory equipment and medical technology.
3. Laboratory equipment and medical technology are inspected and tested when new and according to age, use, and manufacturers' recommendations thereafter and the inspections are documented.
4. Laboratory equipment and medical technology are calibrated and maintained according to manufacturers' recommendations, and the calibration and maintenance are documented.
5. The clinic has a system in place for monitoring and acting on laboratory equipment and medical technology hazard notices, recalls, reportable incidents, problems, and failures.

Radiology and Diagnostic Imaging Services

Standard UNC-AP.11

Radiology and diagnostic imaging services are available to meet patient needs, and all such services meet applicable industry standard radiation protection measures.

Intent of UNC-AP.11

The clinic has a system for providing radiology and diagnostic imaging services required by its patient population, clinical services offered, and health care practitioner needs. Radiology and diagnostic imaging services meet all applicable local and national standards, laws, and regulations.

Measurable Elements of UNC-AP.11

1. Radiology and diagnostic imaging services meet COE Manual standards (if UN clinic).
2. Adequate, regular, and convenient radiology and diagnostic imaging services are available to meet the needs related to the clinic's mission and patient population, the community's health care needs, and emergency needs on a 24/7 basis.

3. The clinic contacts experts in specialized diagnostic areas when needed.

Standard UNC-AP.12

A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services.

Intent of UNC-AP.12

Radiology and diagnostic imaging services provided in the clinic, are under the direction of an individual who is qualified by documented education, training, expertise, and experience, consistent with UN requirements as documented in the Medical Support Manual (when applicable). This individual assumes professional responsibility for the radiology and diagnostic imaging department and the services provided. When this individual provides clinical consultation or medical opinion, he or she is an active licensed- physician, preferably a radiologist.

The radiology and diagnostic imaging leader's responsibilities include:

- implementing, and maintaining policies and procedures;
- administrative oversight;
- maintaining a quality control program;
- recommending outside experts, if needed; and
- monitoring and reviewing all radiology and diagnostic imaging services.

Measurable Elements of UNC-AP.12

1. Radiology and diagnostic imaging services are under the direction of one or more qualified individuals.
2. Responsibilities for implementing, and maintaining policies and procedures are defined and carried out.
3. Responsibilities for administrative oversight are defined and carried out.
4. Responsibilities for maintaining quality control programs are defined and carried out.
5. Responsibilities for recommending outside experts in radiology and diagnostic imaging services are defined and carried out.
6. Responsibilities for monitoring and reviewing all radiology and diagnostic imaging services are defined and carried out.

Standard UNC-AP.13

A radiation safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.

Intent of UNC-AP.13

The clinic has an active radiation safety program. The radiation safety program reflects the risks and hazards encountered. The program addresses safety practices and prevention measures for radiology and diagnostic imaging staff, other staff, and patients.

The radiation safety management program includes:

- compliance with standards addressing facility management and infection control programs;
- availability of safety protective devices appropriate to the practices and hazards encountered;
- the orientation of all radiology and diagnostic imaging staff to safety procedures and practices; and
- in-service education for new procedures and newly acquired or recognized hazardous materials.

Measurable Elements of UNC-AP.13

1. A radiation safety program is in place that addresses potential safety risks and hazards encountered within or outside the department.
2. Identified radiation safety risks are addressed by specific processes or devices that reduce safety risks (such as lead aprons, radiation dosimeters/badges, and the like).
3. Radiology and diagnostic imaging staff are oriented to safety procedures and practices and receive ongoing education and training for new procedures, equipment, and medical technology.

Standard UNC-AP.14

All equipment and medical technology used to conduct radiology and diagnostic imaging studies is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.

Intent of UNC-AP.14

Radiology and diagnostic imaging staff work to ensure that all equipment and medical technology function at acceptable levels and in a manner that is safe to the operator(s). Testing, maintenance, and calibration frequency are related to the use of the equipment and medical technology and its documented history of service.

Radiology and diagnostic imaging develops and implements a program to manage equipment and medical technology that provides for

- identifying and inventorying equipment and medical technology;
- assessing equipment and medical technology use through inspection, testing, calibration, and maintenance;
- monitoring and acting on equipment and medical technology hazard notices, reportable incidents, problems, and failures; and

- documenting the required activities in the program.

Measurable Elements of UNC-AP.14

1. Individual responsible for radiology and diagnostic imaging develops, implements, and documents a program to manage equipment and medical technology.

2. Radiology equipment and medical technology are inspected and tested when new and according to age, use, and manufacturers' recommendations.

3. Radiology equipment and medical technology are calibrated and maintained per manufacturers' recommendations.

4. The clinic has a system in place for monitoring and acting on radiology equipment and medical technology hazard notices, recalls, reportable incidents, problems, and failures.

Chapter 4 - Care of Patients (UNC-CP)

Standard UNC-CP.1

Uniform care is provided to all patients.

Intent of UNC-CP.1

Patients with the same health problems and care needs have a right to receive the same quality of care throughout the clinic. To carry out this principle of one level of quality care requires that the department/service leaders plan and coordinate patient care. In addition, the department/service leaders ensure that the same level of care is available during all hours that the organization is in operation.

Measurable Elements of UNC-CP.1

1. The clinic's department/service leaders collaborate to provide integrated and coordinated care to all patients at all times.

2. The level of care provided to patients is the same throughout the organization.

Standard UNC-CP.2

The care provided to each patient is planned, revised when indicated by a change in the patient's condition and documented in the patient record.

Intent of UNC-CP.2

The plan of care outlines any treatment to be provided to an individual patient. The plan of care identifies a set of actions that the health care team will implement to resolve or support the diagnosis identified by assessment. The overall goal of a plan of care is to achieve optimal clinical outcomes.

The planning process is collaborative and uses the data from the initial assessment and from periodic reassessments performed by physicians, nurses, and other healthcare professionals to identify and to prioritize the treatments, procedures, nursing care, and other care to meet the patient's needs.

One method of developing care plans is to identify and establish measurable goals. Measurable goals can be selected by the responsible physician in collaboration with the nurse and other health care practitioners.

Measurable goals are observable and achievable targets related to patient care and expected clinical outcomes. They must be realistic, specific to the patient, and time-based to provide a means for measuring progress and outcomes related to the plan of care. Examples of measurable, realistic goals include the following:

- The patient will resume and maintain an adequate cardiac output as indicated by a heart rate, rhythm, and blood pressure that are within normal limits.

- The patient will demonstrate proper self-administration of insulin injections.

Measurable Elements of UNC-CP.2

1. The care for each patient is planned.
2. The patient is involved in the planned care.
3. The planned care is revised when indicated by a change in the patient's condition.
4. The planned care is documented in the patient's record.

Standard UNC-CP.3

The clinic implements a uniform process for prescribing patient orders.

Intent of UNC-CP.3

Many patient care activities require a qualified individual to prescribe an order for that activity that must be documented in the patient record. Such activities may include, for example, orders for laboratory testing, administration of medications, specific nursing care, nutrition therapy, rehabilitative therapy, and the like. Patient care activities requiring orders are ordered by individuals qualified to do so.

Such orders must be easily accessible if they are to be acted on in a timely manner. Locating orders on a common sheet or in a uniform location in patient records facilitates the carrying out of orders. Documented orders help staff understand the specifics of an order, when the order is to be carried out, and who is to carry out the order. Orders can be written on an order sheet that is transferred to the patient's record periodically or at discharge, or a computerized order entry system may be used in clinics that are using electronic patient records.

All clinics must ensure that:

- All orders should be in written format. In case of a necessary verbal order, the order must be documented by the person receiving the order and countersigned as soon as possible by the person giving the order.
- Without exemptions written orders are always required for blood and blood products, fluids and medications;
- Diagnostic imaging and clinical laboratory test orders must provide a clinical indication/rationale;
- Only those who are permitted to prescribe do; and
- Orders are to be documented in the patient record.

Measurable Elements of UNC-CP.3

1. The clinic implements a uniform process for prescribing patient orders.
2. Diagnostic imaging and clinical laboratory test orders include a clinical indication/rationale when required for interpretation.
3. Orders are prescribed only by those qualified to do so.
4. Orders are found in a uniform location in patient records.

Standard UNC-CP.4

Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient's record.

Intent of UNC-CP.4

Examples of such procedures and treatments include all invasive and non-invasive diagnostic procedures and treatments. Information about who requested the procedure or treatment and the reason for the procedure or treatment are included in the documentation.

Measurable Elements of UNC-CP.4

1. Procedures and treatments performed are documented in the patient's record.
2. The person requesting, and the reason for requesting the procedure or treatment are documented in the patient's record.
3. The results of procedures and treatments performed are documented in the patient's record.

Standard UNC-CP.5

The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines.

Intent of UNC-CP.5

The frightened, confused, comatose, or emergency patient is unable to understand the care process when care needs to be provided efficiently and rapidly.

Clinics care for patients with a variety of health care needs. Some patients are considered high-risk because of their age, their condition, or the critical nature of their needs.

Policies, guidelines, and clinical pathways for managing the care of high-risk patients are important tools to help staff understand and respond in a thorough, competent, and uniform manner. Ambulatory care organization leadership is responsible for:

1. Identifying the patients and services considered high-risk in the organization;

2. Using a collaborative process to develop guidelines and clinical pathways for care; and

3. Training staff in implementing the guidelines and clinical pathways.

Policies, guidelines, and clinical pathways for care must be tailored to the particular at-risk patient population or high-risk service to be appropriate and effective in reducing the related risk. It is particularly important that they identify:

1. How planning will occur, including the identification of differences between adult and pediatric populations, or other special considerations;

2. The documentation required for the care team to work and to communicate effectively;

3. Special consent considerations, if appropriate;

4. Patient-monitoring requirements;

5. Special qualifications or skills of staff involved in the care process; and

6. The availability and use of specialized medical technology.

The clinic establishes and implements guidelines and procedures for the patient populations and services identified as high-risk in the organization. These include, when present in the organization, at least the following:

1. Emergency patients
2. Care of patients with a communicable disease
3. Care of immunosuppressed patients
4. Care of patients with emotional or psychiatric disorders
6. Care of patients receiving chemo- and radiation therapy

Additional high-risk patients and services are included when they are represented in the clinic's patient population and in the services it offers. The clinic uses measurement information to evaluate the quality of the services provided to high-risk patients and integrates that information into the organization's overall quality improvement program.

Measurable Elements of UNC-CP.5

1. Clinic leadership has identified the high-risk patients and services.
2. When high-risk services are provided by the clinic, leadership establishes and implements guidelines and procedures for those services and for the care of high-risk patients.
3. Staff members have been trained and utilize the guidelines and procedures for care.
4. The clinic evaluates the quality of high-risk services as part of the quality improvement program.

Standard UNC-CP.6

Clinical staff are trained to recognize and respond to changes in a patient's condition.

Intent of UNC-CP.6

Serious adverse events such as unexpected death and cardiac arrest are often preceded by observable physiological abnormalities. Early identification of deterioration may improve outcomes and lessen the intervention required to stabilize patients whose condition deteriorates. [3] There is evidence that the warning signs of clinical deterioration are not always identified or acted on appropriately. Reasons may include:

- Not monitoring physiological observations consistently or not understanding observed changes in physiological observation;

[3] https://www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/observation-and-response-charts/

- Lack of knowledge of signs and symptoms that could signal deterioration;
- Lack of formal systems for responding to deterioration; and
- Failure to communicate clinical concerns, including in handover situations.

Measurable Elements of UNC-CP.6

1. The clinic implements an observation and response process for recording physiological observations that incorporates triggers to escalate care when deterioration occurs.
2. The clinic tracks patients whose condition may be deteriorating.
3. Action is taken when physiologic triggers are met.

Resuscitation Services

Standard UNC-CP.7

Resuscitation services are available throughout the clinic.

Intent of UNC-CP.7

Resuscitation services can be defined as clinical interventions for the emergency care of patients experiencing a critical, life-threatening event, such as cardiac or respiratory arrest. When a cardiac or respiratory arrest occurs, the immediate initiation of chest compressions or respiratory support may mean the difference between life and death or, at the very least, may help avoid potentially serious brain damage.

Successful resuscitation of patients in cardiopulmonary arrest is dependent on critical interventions, such as early defibrillation and accurate implementation of basic life support. These services must be available to all patients, regardless of day and time of day.

Measurable Elements of UNC-CP.7

1. Resuscitation services are available and provided during all hours of operation and throughout all areas of the clinic.
2. Medical technology and medications for resuscitation are standardized and available for use based on the needs of the population served.
3. All staff who provide patient care are trained to provide basic and advanced life support services.

Food and Nutrition Therapy (If Applicable)

Standard UNC-CP.8

When patients remain in the clinic for extended periods, food appropriate for the patient's nutritional status and consistent with his or her clinical condition is available.

Intent of UNC-CP.8

Nutrition is important to the patient's overall healing process. Patients will have differing needs depending on their physiological status, treatment plan, and known allergens.

Measurable Elements of UNC-CP.8

1. Food appropriate for the patient's condition and religion is available for patients who have extended stays in the clinic.
2. Orders are based on patients' nutritional status, clinical care needs, and dietary preferences as appropriate.
3. Prior to patients being fed, the patient is identified as having any (or no) known food allergies.
4. When families provide food, they are educated about the patients' diet limitations.

Standard UNC-CP.9

Patients are supported in managing pain effectively.

Intent of UNC-CP.9

Pain can be a common part of the patient experience, especially in crisis and/or emergency situations. It may also be an expected part of certain treatments, procedures or examinations. Whatever the origin of pain, unrelieved pain has adverse physical and psychological effects. Patients in pain have the right to appropriate assessment and management of pain.

Measurable Elements of UNC-CP.9

1. Based on the scope of services provided, the clinic has processes to manage patients in pain.
2. When pain is an expected result of planned treatments, procedures, or examinations, patients are informed about the likelihood of pain and options for pain management and these are documented in the patient's medical record.
3. Patients in pain receive care according to pain management guidelines and according to patient goals for pain management.
4. Based on the scope of services provided, the clinic has processes to communicate with and educate patients about pain.

Chapter 5 - Medication Management (UNC-MM)

Standard UNC-MM.1

Medication use is safely managed. [4]

Intent of UNC-MM.1

Medications are frequently used for treating illness and moderating symptoms and thus form an important element of the care process in most clinics. The clinic's leaders and other factors determine how the clinic will meet the medication needs of its patients. This decision is based on such factors as the clinic's mission, availability of medications in the community, and types of services provided. Therefore,

- patients may be given prescriptions to obtain medications at community pharmacies;
- medications may be dispensed within the organization from a pharmacy that is operated by the organization or by contract with an outside source; or
- medications may be managed by each practitioner within the patient care areas, with the practitioner administering medications and providing sample medications.

Whatever the choice, medication use must be organized effectively and efficiently to meet patient needs. On-site pharmacies must meet all applicable laws and regulations. Medications made available within the clinic to patients and to practitioners for administration are managed through a defined medication management program. Healthcare practitioners involved in ordering, dispensing, administering, and patient monitoring processes are involved in the development and ongoing evaluation of the medication management program.

Measurable Elements of UNC-MM.1

1. The clinic develops and implements a program to guide medication management and use that meets UN requirements and applicable laws and regulations.
2. Medication use is overseen by a qualified individual.

Storage of Medications

Standard UNC-MM.2

Medications are properly and safely stored.

Intent of UNC-MM.2

Medication use is a complex system of processes that has many risk points. There must be a qualified individual familiar with and responsible for all parts of the medication use system. Considering that field conditions may create challenges in storing medications, the clinic uses standardized procedures to ensure medication storage is secure, the system minimizes errors in look-alike, sound-alike drugs, and the clinic strictly maintains the cold chain for medications that need temperature protection.

Measurable Elements of UNC-MM.2

1. Medications are stored under conditions suitable for product stability. All medication storage areas are periodically inspected to ensure that medications are stored properly.

2. Controlled substances are accurately accounted for using a process that includes verification by at least two staff members.

3. The clinic follows the UN requirements on Maintenance of Cold Chain for Medication and provides documentation to demonstrate compliance with the policy.[5]

Standard UNC-MM.3

Medications are prepared and dispensed in a safe and clean environment.

Intent of UNC-MM.3

Pharmacists and others with proper training and experience prepare and dispense medications in a clean and safe environment and according to professional standards of practice. This may include how medication preparation areas are to be cleaned and when a mask should be worn.

Measurable Elements of UNC-MM.3

1. Medications are prepared and dispensed in a safe and clean environment.

2. All staff who prepare and dispense medications have been properly trained.

Standard UNC-MM.4

A system is used to safely dispense the right drug, in the right dose to the right patient at the right time and via the right route.

Intent of Standard 4

The clinic dispenses medications in the most ready-to-administer form possible to minimize opportunities for error during distribution and administration.

Measurable Elements of UNC-MM.4

1. There is a uniform medication dispensing and distribution system in the clinic.

2. Medications are dispensed in the most ready-to-administer form available.

Standard UNC-MM.5

Medications are monitored for patient adherence, effectiveness, and adverse medication effects.

Intent of UNC-MM.5

Based on monitoring, the dosage or type of medication can be adjusted when needed. Monitoring medication effects includes observing and documenting any adverse effects. The clinic has a policy

[5] Medical Support Manual for United Nations Field Missions, 3rd Edition, Chapter 12, Annex A, Pages 196-197

that identifies all adverse effects that are to be recorded and those that must be reported. The clinic establishes a mechanism for reporting adverse events when required and the time frame for reporting.

Measurable Elements of UNC-MM.5

1. Patient adherence in taking medications, medication effectiveness, and adverse medication effects on patients are monitored.

2. Medication adverse effects on patients are monitored and documented.

3. Adverse effects are documented in the patient's record and reported as required.

Chapter 6 - Patient and Family Education (UNC-PE)

Standard UNC-PE.1

The clinic provides education that supports patient participation in care decisions and care processes.

Intent of UNC-PE.1

Clinics educate patients so that they have the knowledge and skills to participate in the patient care processes and care decisions. The clinic builds education into care processes based on its mission, services provided, and patient population. Education is planned to ensure that every patient is offered the education he or she requires.

Measurable Elements of UNC-PE.1

1. The clinic plans education consistent with its mission, services and patient population.
2. There is an established structure or mechanism for education throughout the clinic.
3. The education includes instruction on how to correctly use prescribed medications and when to return for continuing or follow-up care.
4. Instruction on the correct use of medication(s) is available in flyers and/or other printed materials in a language that the patient can understand.

Section III - Administration-Focused Standards

Chapter 7 - Quality and Patient Safety (UNC-QS)

Standard UNC-QS.1

The clinic follows the UN adverse event reporting process.

Intent of UNC-QS.1

The frequency, magnitude and impact of adverse events can only be known if data are collected and analyzed. A difficult challenge is to develop a reporting process that is free of punitive overtones and/or actions. Without this, staff will be fearful, adverse events will be under-reported, and any resulting data and data analysis will be flawed. The adverse event reporting process should be clearly defined, and staff should be well-educated on the process of reporting. Adverse event reports must be completed on at least the following:

a) Patient care-management related adverse preventable events;
b) Invasive procedure performed on the wrong site or wrong patient;
c) Wrong invasive procedure performed on a patient;
d) All medication errors;
e) All serious adverse drug events as defined by the clinic;
f) Patient suicide, attempted suicide, or self-harm that is preventable and results in death or injury;
g) Patient fall that is preventable and results in harm;
h) Patient harm resulting from failure to follow up or communicate laboratory, pathology, or radiology results;
i) Other adverse events; for example, health care associated infections, infectious disease outbreaks, documentation deficiencies, etc.;
j) Needle sticks, communicable diseases and other staff injuries; and
k) Near misses.

Measurable Elements of UNC-QS.1

1. Leaders are committed to the adverse event reporting process.

2. The clinic uses the UN Adverse Event Reporting Form.

3. The events to be reported include a) through k) in the Intent Statement.

4. The reporting process is implemented, and data are collected for events that meet the definition.

5. Adverse events that result in injury to a patient are reported to the Medical Services Director immediately when they are identified.

Standard UNC-QS.2

Adverse events are analyzed.

Intent of UNC-QS.2

One of the most powerful risk-reduction activities is investigating the underlying cause (root cause) of a significant adverse event and making process changes to prevent the event from recurring. Certain events, such as severe injury or unanticipated death of a patient trigger a root cause analysis independently. Other event data can be aggregated to understand trends and patterns, such as patient falls and medication errors.

Measurable Elements of UNC-QS.2

1. An established process for adverse event analysis (root cause analysis), is implemented.
2. Analysis is used consistently to learn from adverse events and reported to senior management and UN Medical Director (If UN/TCC clinic).
3. The analysis results in process changes to reduce the risk of similar events.

Standard UNC-QS.3

Patient experience is monitored.

Intent of UNC-QS.3

Patient experience with the care process, the care environment and the staff involved in their care is valuable information that will help identify quality and patient safety issues. This information is useful in identifying priorities for improvement and for understanding if improvements increase patient experience.

Measurable Elements of UNC-QS.3

1. Collecting patient experience information using a patient experience survey tool is used to monitor patient experience.
2. Patient experience is routinely monitored and the data analyzed and forwarded to the medical director on a quarterly basis.
3. Patient experience data are communicated to staff and are used to set priorities for improvement or for further evaluation.
4. This data is communicated to the CMO and the UN Medical Director (If UN/TCC clinic).

Standard UNC-QS.4

There is a process to receive and evaluate staff feedback.

Intent of UNC-QS.4

Gathering staff feedback on care processes, the care environment and other aspects of their daily work will help identify quality and patient safety issues. This information is useful in identifying priorities for improvement and for understanding if improvements already made are positive and effective.

Measurable Elements of UNC-QS.4

1. There is an organized process for collecting feedback from staff.

2. Staff feedback via the survey on safety culture is routinely monitored and the data analyzed.

3. Trends in the results of staff feedback are used to set priorities for improvement or for further evaluation.

4. Aggregated feedback is periodically shared with staff.

Standard UNC-QS.5

Clinical guidelines and pathways are used to support consistency in care.

Intent of UNC-QS.5

Clinical guidelines and pathways are tools to adapt good science to practice and thereby reduce the variation among care providers and outcomes for patients. Clinical pathways and guideline that relate to the patient population and clinical services, should be adopted.

Measurable Elements of UNC-QS.5

1. Guidelines and pathways identified by the UN should be used.

2. Guidelines and pathways are used consistently for the identified patient populations.

3. Data on the use of clinical pathways and guidelines are evaluated to determine consistency in use and to inform the need for future adaptation.

Standard UNC-QS.6

Clinical outcomes for special conditions identified from time to time by the UN Medical Director are monitored and reported to the UN.

Intent of UNC-QS.6

There will be times when conditions in the field warrant focused attention, such as during an outbreak of an infectious disease, increased incidence of chronic disease, new epidemics, or increased incidences of non-communicable diseases with unknown etiology. The Medical Services Director will determine when such a condition warrants additional data collection and outcome reporting, and will issue a directive and supply a required form for documentation. A special condition may be identified in many ways, such as by the clinic CMO, WHO, community leaders, and so on.

Measurable Elements of UNC-QS.6

1. The Head of the Medical Services notifies the UN Medical Director if a potentially high-risk clinical condition is identified in the clinic, among the troops, or within the community where the clinic is located.

2. The clinic complies with the requirement for clinical outcome measurement and reporting for special conditions when notified by the DHMOSH.

3. The clinic uses the form provided by the DHMOSH to document clinical outcomes and provides documentation within the timeframe specified.

Standard UNC-QS.7

Leaders are committed to building a safety culture within the clinic.

Intent of UNC-QS.7

An organization improves safety and quality when leaders are committed to and visibly demonstrate that they are committed to a safety culture within the clinic. A safety culture is built on trust. Leaders not only encourage staff to work toward improvement, staff members are urged to take action when it is needed without fear of reprisal. Staff feel enabled and encouraged to openly share safety information, and this, in turn, drives improvement. When a clinic does not have a safety culture, staff members are often unwilling to report errors, near misses and unsafe conditions because they fear they will blamed or punished. Without this information, the opportunity to improve safety is lost.

Leaders can consistently demonstrate their support of a safety culture by educating staff, providing written materials that define a safety culture, and most importantly, by providing a positive response to incident reporting. When they make changes or improvements based on incident reporting data, this further demonstrates the value of reporting and reinforces the process.

Measurable Elements of UNC-QS.7

1. Leaders demonstrate that they are committed to a safety culture by visibly demonstrating they support a process of continuous improvement.
2. Staff members are actively encouraged to engage in incident reporting.
3. The aggregated results of incident reporting are shared with staff.
4. Improvements are implemented based on data gathered through the incident reporting system

Chapter 8 - Prevention and Control of Infections (UNC-PI)

Standard UNC-PI.1

The clinic designs and implements a comprehensive program to reduce the risk of healthcare associated infections in patients and staff.

Intent of UNC-PI.1

For an infection prevention and control program to be effective, it must be comprehensive, encompassing both patient care and staff health. The program identifies and addresses the infection issues that are epidemiologically important to the clinic. In addition, the program requires a range of strategies that cross all levels of the clinic based on the organization's size, geographic location, services, and patients. The program includes hand hygiene, systems to identify infections and to investigate outbreaks of infectious diseases, and oversight for improving the safe use of antimicrobials. The periodic assessment of risk and the establishing of risk-reduction goals guide the program.

The program is developed and implemented in a multidisciplinary manner and is supported by human and technical resources to meet its objectives and be effective. The program is implemented in all areas of the organization in which patients, staff, and visitors can be found. Staff are educated regarding their role in the program.

Measurable Elements of UNC-PI.1

1. One or more individuals oversee the infection prevention and control program.
2. The individual(s) is qualified for the clinic's size, complexity of activities, and level of risks, as well as the program's scope.
3. The individual(s) fulfills program oversight responsibilities as assigned.
4. The program incorporates a range of strategies that includes systematic and proactive surveillance activities to determine usual (endemic) rates of infection.
5. The program includes systems to investigate outbreaks of infectious diseases.
6. Risk-reduction goals and measurable objectives are established and reviewed.

Standard UNC-PI.2

All patient and staff areas of the clinic are included in the infection prevention and control program.

Intent of UNC-PI.2

Infections can enter the clinic via patients, staff, volunteers, visitors, and other individuals, such as trade representatives. Thus, all areas of the clinic where these individuals are found must be included in the program of infection surveillance, prevention, and control.

Measurable Elements of UNC-PI.2

1. All patient care areas of the clinic are included in the infection prevention and control program.

2. All staff areas of the clinic are included in the infection prevention and control program.

3. All visitor areas of the clinic are included in the infection prevention and control program.

Standard UNC-PI.3

The clinic undertakes specific activities to establish the focus of the healthcare associated infection prevention and reduction program.

Standard UNC-PI.4

The clinic tracks infection risks, infection rates, and trends in healthcare associated infections to reduce the risks of those infections.

Intent of UNC-PI.3 and UNC-PI.4

Each clinic must identify those epidemiologically important infections, infection sites, and associated devices, procedures, and practices that will provide the focus of efforts to prevent and to reduce the risk and incidence of healthcare associated infections.

Clinics collect and evaluate data on at least the following relevant infections and sites:

a) Surgical sites—such as their care and type of dressing and associated aseptic procedures;

b) Epidemiologically significant diseases and organisms, multi-drug resistant organisms, highly virulent infections; and

c) Emerging or reemerging infections within the community.

The infection prevention and control process is designed to lower the risk of infection for patients, staff, and others. To reach this goal, the clinic must proactively identify and track risks, rates, and trends in healthcare associated infections. The clinic uses measurement information to improve infection prevention and control activities and to reduce healthcare associated infection rates to the lowest possible levels.

Measurable Elements of UNC-PI.3

1. The clinic has established the focus of the program through the collection of data

2. The data collected are analyzed to identify priorities for reducing rates of infection.

3. This data is shared with the UN Medical Director (If UN clinic).

4. Infection control strategies are implemented to reduce the rates of infection for the identified priorities.

Measurable Elements of UNC-PI.4

1. Healthcare-associated infection risks, rates, and trends are tracked.

2. Processes are redesigned based on risk, rate, and trend data and information.

3. The clinic assesses the infection control risks at the time of each staff rotation.

Standard UNC-PI.5

The clinic reduces the risk of infection through proper disposal of biomedical waste.[6,7]

Intent of UNC-PI.5

The proper disposal of waste contributes to the reduction of infection risk in the clinic. This is true for the disposal of body fluids and materials contaminated with body fluids, and the disposal of blood and blood components. Because all staff may not be aware of which waste is or could be infectious, all biomedical waste must be disposed of in a uniform and safe way that protects the health care worker and the community.

Measurable Elements of UNC-PI.5

1. Disposal of infectious waste and body fluids is managed as per an SOP on waste management to minimize infection transmission risk. UN clinics follow The Environmental Policy for Field Missions regarding medical waste management[8].

2. If a UN clinic, the handling and disposal of blood and blood products are managed as per UN policy laid out in the MSM[9] to minimize infection transmission risk.

3. Staff has guidance on proper disposal of infectious medical waste via incineration.

4. There is a uniform disposal process that includes all types of infection waste collection and proper disposal.

5. The infectious medical waste disposal process is part of the clinic's infection prevention and control process and is regularly evaluated and improved when indicated.

Standard UNC-PI.6

The clinic implements practices for safe handling and disposal of sharps and needles.

Intent of UNC-PI.6

One of the dangers of needle stick injuries is the possible transmission of blood-borne diseases. Incorrect handling and improper disposal of sharps and needles present a major staff safety challenge. Work practices influence the risk of injury and potential exposure to disease. Identifying and implementing evidence-based practices to reduce the risk of injury from sharps ensures that exposure to such injuries is minimal. Clinics need to provide staff with education related to safe handling and management of sharps and needles.

Proper disposal of needles and sharps also reduces the risk of injury and exposure. Proper disposal includes the use of containers that are closable, puncture-proof, and leak proof on the sides and the bottom. Containers should be easily accessible to staff and should not be overfilled.

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[6] Medical Support Manual for United Nations Field Missions, Chapter 9, J, K, L, Pages 99-100
[7] Environmental Policy for UN Field Missions1 June 2009, DPO/DOS 2009.6

[8] The Environment Policy for Field Missions, 1 June 2009, DPO/DOS 2009.6
[9] Medical Support Manual for United Nations Field Missions, 3rd Edition, Chapter 9, Pages 99-100, J, K,L

Disposal of discarded needles, scalpels, and other sharps, when not done properly, can pose a health risk to the general public and to those who work in waste management. Clinics must dispose of sharps and needles safely to ensure the proper disposal of medical waste containers and do so in accordance with UN policy and SOP.

The clinic follows the UN policy that adequately addresses all steps in the process, including identifying the proper type and use of containers, the disposal of the containers, and the surveillance of the process of disposal.

Measurable Elements of UNC-PI.6

1. If UN clinic, implements the UN practices to reduce the risk of injury and infection from the handling and management of sharps and needles. Otherwise there is an industry standard protocol for this.

2. Sharps and needles are collected in dedicated, closable, puncture-proof, leak proof containers that are not reused.

3. The clinic disposes of sharps and needles safely to ensure the proper disposal of sharps containers in dedicated incinerators.

Standard UNC-PI.7

The clinic reduces the risk of infections associated with the storage of food.

Intent of UNC-PI.7

When patients are in the clinic for extended periods of time, the clinic must provide for the safe and accurate provision of food and nutrition products by ensuring that the food is stored and prepared at temperatures that prevent the risk of bacterial growth.

Measurable Elements of UNC-PI.7

1. The clinic stores food and nutrition products using sanitation, temperature, light, moisture, ventilation, and security in a manner that reduces the risk of infection.

2. The clinic prepares food and nutrition products using proper sanitation and temperature.

Standard UNC-PI.8

Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.

Intent of UNC-PI.8

Along with hand hygiene, barrier techniques are essential to any program to reduce the risk of infections in patients and staff. To be effective, the supplies must be available, readily accessible, used, and disposed of correctly.

Measurable Elements of UNC-PI.8

1. The situations in which barrier techniques are to be used have been identified and made known to staff.

2. Barrier techniques are used for identified situations, supplies are available and accessible, and the techniques are used correctly.

3. Surface disinfecting procedures are implemented for areas and situations in the clinic identified as at risk for infection transmission.

4. Surface disinfectants are used according to manufacturer instructions.

5. Soap, disinfectants, and towels or other means of drying are located in areas where hand-washing and hand-disinfecting procedures are required.

Chapter 9 - Governance, Leadership and Direction (UNC-GL)

Providing excellent patient care requires effective leadership. Effective leadership begins with understanding the various responsibilities and authority of individuals in the clinic and how these individuals work together. Those who govern, manage, and lead a clinic have both authority and responsibility. Collectively and individually, they are responsible for complying with standards and regulations and for meeting the clinic's responsibility to the patient population served.

Over time, effective leadership helps overcome perceived barriers and communication problems between departments and services in the clinic, and the clinic becomes more efficient and effective. Services become increasingly integrated. The integration of all quality management and improvement activities throughout the clinic results in improved patient outcomes.

Providing excellent patient care, especially in challenging and/or emergency situations, requires purposeful, committed leaders. Those who govern and lead UN clinics have a great deal of authority and responsibility, and their leadership ultimately influences the success of patient outcomes and how well the clinic meets its overall mission. Effective leaders dedicate themselves to continuous improvement through detailed knowledge of what is going on in their clinic, understand where assistance and/or oversight is needed, and monitor performance to required standards and regulations.

Standard UNC-GL.1

Leadership responsibilities and accountabilities are identified.

Intent of UNC-GL.1

It is important that there is a clear understanding of which leaders are responsible for setting the mission, plan and policies of the clinic and how the oversight of daily operations is managed. This level of transparency makes for clear lines of authority and accountability and is fundamental to an organizational culture of quality. Resource decisions needed to advance quality and safety are made at this level.

Measurable Elements of UNC-GL.1

1. There is a written, up-to-date document that identifies accountable leaders by name and position.

2. The individuals are carrying out their responsibilities.

3. For UN clinics in Peacekeeping missions, how individuals carry out their responsibilities has been evaluated by the FMO and CMO; results are reported back to DHMOSH quarterly and measures have been taken to continuously improve the results of their efforts. In Case of AFP Clinics, this evaluation will be conducted by DHMOSH through a survey.

Standard UNC-GL.2

Leadership is structured to promote quality and patient safety.

Intent of UNC-GL.2

Clear and consistent leadership from the most senior leaders of the clinic is necessary for a culture of quality and safety. Without clear leadership, a culture of safety will not develop, and quality and patient safety will not be viewed as a clinic priority.

Measurable Elements of UNC-GL.2

1. The leaders are educated and trained on at least the basics of quality improvement principles, including measurement, aggregation and evaluation of clinical outcome data.

2. Leaders actively promote quality improvement activities in the clinic.

Chapter 10 - Facility Management and Safety (UNC-FS)

Overview

Clinics house a significant amount of equipment, hazardous materials, and many types of patient supplies. Clinics must take appropriate actions to ensure that they provide as protective and supportive environment as possible, taking into account the challenging circumstances of UN clinics around the world. Reducing environmental risks requires leadership commitment to safety, staff training, and regular inspection, maintenance, and monitoring.

Standard UNC-FS.1

The clinic is thoroughly inspected to ensure awareness of risks that could affect patients and staff, and to plan for continuously improving the safety of the environment.

Intent of UNC-FS.1

To protect patients from risks in the health care environment, the first step is for the clinic to know the location, nature, and severity of the risks. This inspection covers a full range of potential risks, from broken or unstable furniture and locked or blocked fire exits, to faulty biomedical equipment and missing signs. There should be an effort to systematically reduce or eliminate those risks.

Measurable Elements of UNC-FS.1

1. The clinic has a documented facility inspection SOP to identify and list healthcare environment risks of all types.
2. Risks are listed and identified in terms of severity and priority.
3. The risks identified are systematically reduced or eliminated, and the list is updated through periodic inspections.

Standard UNC-FS.2

The clinic controls the use of hazardous materials.

Intent of UNC-FS.2

Hazardous materials include diagnostic and treatment materials, chemicals in the clinical laboratory, and caustic cleaning supplies. It is important to know the location of all hazardous materials and to manage the proper labeling, storage and handling of these materials. Spilled hazardous materials are reported, investigated and cleared in a manner that does not expose patients and staff to undue risk.

Measurable Elements of UNC-FS.2

1. There is a list of the location, type, and amount of hazardous materials within the clinic.
2. Based on the list, there is a plan for safe and proper labeling, storage, and use of hazardous materials.
3. Spills and accidents involving hazardous materials are documented on incident reports.

4. Spills and accidents are investigated and measures are taken to prevent future incidents and/or improve the response to such spills and accidents.

Standard UNC-FS.3

There is an SOP to ensure that all occupants of the clinic are safe from fire, smoke and other emergencies.

Intent of UNC-FS.3

Although fires are not common in clinics, when they occur they can have devastating outcomes. An effective approach to fire safety includes fire risk reduction, appropriate reaction when a fire occurs, and staff knowledge and training to ensure patients and staff can exit safely or move to safety in another part of the building.

Measurable Elements of UNC-FS.3

1. There is a fire safety program that includes prevention, early detection, abatement, and safe exit of staff and patients.
2. The program covers the entire clinic and is tested at least annually.
3. Results from annual testing are reported to the head of the clinic and are used to continuously improve the program though staff education.

Standard UNC-FS.4

There is an organized program for the safe management of biomedical equipment.

Intent of Standard UNC-FS.4

The safe use and maintenance of biomedical equipment is critical to the safety of patients and staff. Broken or unusable equipment can potentially compromise the diagnostic and treatment process for patients. Poorly maintained equipment may not give accurate results and frequent equipment breakdowns can delay needed tests, further compromising patient care.

Measurable Elements of UNC-FS.4

1. The clinic has a comprehensive inventory of all biomedical equipment.
2. The clinic has a program for inspecting, testing, and maintaining biomedical equipment by qualified individuals.
3. Equipment breakdowns are tracked, and data are used as part of the program to reduce the number of breakdowns.

Standard UNC-FS.5

Safe drinking water and electrical power are available during hours of clinic operation to meet essential patient care needs.

Intent of UNC-FS.5

Clean water and electricity are needed for many activities in a clinic and must be available at all times during clinic hours of operation.

Measurable Elements of UNC-FS.5

1. There is a stable source of safe drinking water and electrical power for the clinic during hours of operation.

2. Alternate sources of safe drinking water and electrical power are available if the primary source is disrupted, when the clinic chooses to continue to provide services during a disruption.

Chapter 11 - Staff Health and Safety (UNC-SH)

Standard UNC-SH.1

There is a program to reduce health hazards for staff and to provide safe working conditions.

Intent of UNC-SH.1

A healthy workforce is essential to provide quality and safe patient care. Where risk resides, there needs to be proactive steps to protect workers.

Staff may bring infectious diseases into the clinic from the community, spread infections between patients, and may be absent or ineffective in their work if they are injured or ill.

Hazardous materials must be labeled and stored safely to reduce staff harm, and there needs to be a means to wash or decontaminate those splashed or exposed.

Measurable Elements of UNC-SH.1

1. The clinic has a process for reporting when staff injuries occur and staff are educated regarding this process.
2. The clinic attends to staff injuries and health issues quickly when incidents occur.
3. The clinic has a proactive program to identify and reduce staff safety risks.
4. The clinic collects and analyzes data on staff risks and injuries and takes action to reduce health incidents.
5. The clinic can demonstrate increased safety and reduced health incidents as a result of action taken.

Chapter 12 - Staff Qualifications and Education (UNC-SQ)

Patients assume that the health care professionals providing their care and treatment are competent and capable. The clinic has a moral, ethical and legal obligation to ensure that this is true.

Many health care professionals, such as physicians, nurses, and others, are permitted by law or regulation to work without supervision and thus without some of the checks and balances that reduce risk. It is essential that all health care professionals have appropriate and valid credentials and are competent to provide the care and treatment to patients assigned by the clinic. Peacekeeping and AFP clinics follow all requirements in the MSM.[10]

Standard UNC-SQ.1

Technical clearance for all medical service providers is provided to TCC/PCC during the force generation process and for subsequent rotation of the TCC/PCC medical personnel. Proper credentialing of all civilian medical personnel is undertaken.

Intent of UNC-SQ.1

Medical staff should be selected within a reasonable time of their assignment to a field mission to provide sufficient time to complete the technical clearance requirement at least 3 months before their deployment in the field. Technical clearance is required for Physician/Medical Doctor, Specialist Physician/Doctor, Clinical Psychologist, Dentist, Pharmacist, Registered Nurse/Nurse, Specialist Nurse, Medical Technician, Paramedic, and Ambulance Medic. The documents that UNHQ requires for this technical clearance are:

a) University certificate/diploma
b) Specialization certificate (if applicable)
c) Any relevant certificates for trainings or workshops attended
d) A valid registration or license to practice
e) A curriculum vitae or a personal history profile clearly mentioning, with dates, the work experience of the candidate.

Measurable Elements of UNC-SQ.1

1. All medical service providers receive technical clearance during the force generation process and/or for subsequent rotation, at least 3 months prior to their deployment in the field. Civilian medical personnel also go through a defined credentialing process.

2. There is documented technical clearance for all current medical service providers.

Standard UNC-SQ.2

All physicians deployed in field missions follow the ethical code for medical practitioners and the principles of medical ethics as detailed in the Medical Support Manual[11]

[10] Medical Support Manual for United Nations Field Missions, Chapter 8, Pg. 81
[11] Medical Support Manual for United Nations Field Missions, Chapter 8, Pg. 85

Intent of UNC-SQ.2

Medical ethics is a system of moral principles that apply values and judgments to the practice of medicine. As a member of this profession, a physician must first and foremost recognize his/her responsibility to patients as well as to society, to other health professionals, and to self. The UN has defined a minimum standard of conduct required of all medical practitioners in the service of the United Nations. This standard of conduct is in addition to any national code of ethics that may be imposed in the medical practitioners' home country.

Measurable Elements of UNC-SQ.2

1. All physicians and other professional clinical staff are aware of the UN ethical code for medical practitioners as detailed in the MSM[12].
2. All physicians and clinicians follow the ethical code of conduct.
3. There is a defined process in place to take appropriate action if the ethical code for medical practitioners is not followed.

Standard UNC-SQ.3

The clinic follows the UN SOP for the management of staff who are unsafe to practice.

Intent of UNC-SQ.3

Patients have the right to expect that the doctors, nurses and other healthcare professionals caring for them are not only competent by licensure and credentialing but are also safe to practice. A health care professional is unsafe to practice, or impaired, when his or her ability to treat patients is compromised and they are unable to fulfil professional responsibilities in a safe way. Physical, emotional and psychological issues may contribute to unsafe practice. Evidence of impairment may display as physical aggression, emotional outbursts or other erratic behaviors that impact a staff member's ability to interact professionally with colleagues and provide appropriate care for patients. Clinics must have a process to gather and evaluate evidence of impairment and to act to remove the impaired professional from patient care responsibilities, if necessary.

Measurable Elements of UNC-SQ.3

1. The clinic has a process in place for the management of staff who are unsafe to practice.
2. All staff members are aware of the process and know how to document and submit anonymous observations of unsafe behaviors.
3. Complaints of unsafe practice are investigated in a timely way.
4. Variations in patient outcomes between physicians or among patients under the care of the same physician are reviewed.
5. Appropriate action is taken if there is a determination of unsafe practice.

[12] Medical Support Manual for United Nations Field Missions, Chapter 8, Pages 85-87

Standard UNC-SQ.4

Staff members are oriented to their job responsibilities, job assignments, and work location.

Intent of UNC-SQ.4

Inadequate job orientation is a major contributor to adverse events in healthcare organizations. Such events include medication errors, not knowing how to operate medical equipment and injuring patients, and many other situations that can lead to patient harm or even death. A thorough job orientation to the work that the professional is to perform is essential for patient safety.

Measurable Elements of UNC-SQ.4

1. There is a comprehensive job orientation for all staff.
2. The job orientation includes temporary workers, contract workers and volunteers.

Chapter 13 - Management of Information (UNC-MI)

Standard UNC-MI.1

The clinic plans and designs information management processes to meet internal and external information needs.

Intent of UNC-MI.1

Information is generated and used during patient care and for managing a safe and effective clinic. The ability to capture and to provide information requires effective planning.

Measurable Elements of UNC-MI.1

1. The information needs of those who provide clinical services are considered in the planning process.
2. The information needs of those who manage the clinic are considered in the planning process.
3. The information needs and requirements of individuals and agencies outside the clinic are considered in the planning process.

Standard UNC-MI.2

Information privacy, confidentiality, and security, including data integrity, are maintained.

Intent of UNC-MI.2

The clinic maintains the privacy and confidentiality of data and information and is particularly careful about preserving the confidentiality of sensitive data and information. The balance between data sharing and data confidentiality is addressed. Maintaining data integrity is an important aspect of information management. Policies and procedures address security procedures that allow only authorized staff to gain access to data and information. Access to different categories of information is based on need and decreed by job title and function. An effective process defines:

• who has access to data and information, including the medical record;
• the information to which an individual has access;
• the user's obligation to keep information confidential;
• the process for maintaining data integrity; and
• the process followed when confidentiality, security, or data integrity are violated.

Measurable Elements of UNC-MI.2

1. The clinic has a written SOP that protects the confidentiality, security, and integrity of data and information.
2. The clinic's process is based on and consistent with the above-mentioned SOP.
3. The process identifies the level of confidentiality maintained for different categories of data and information.
4. Those persons who need or have a job position permitting access to each category of data and information are identified.

5. Compliance with the process is monitored, and actions are taken when confidentiality, security, or data integrity are violated.

Standard UNC-MI.3

The clinic complies with the UN medical record retention schedule[13].

Intent of UNC-MI.3

Medical records and other data and information are retained per UN rules and regulations. The retention of records, data, and information is consistent with the confidentiality and security of such information. When the retention period is complete, medical records and other records, data, and information are destroyed in a manner that does not compromise confidentiality and security.

Measurable Elements of UNC-MI.3

1. The UN medical retention schedule is followed regarding the retention time of patient clinical medical records and other data and information.
2. The retention process provides expected confidentiality and security.
3. Records, data, and information are destroyed in a manner that does not compromise confidentiality and security.

Standard UNC-MI.4

Records and information are protected from loss, destruction, tampering, and unauthorized access or use.

Intent of UNC-MI.4

Medical records and other data and information are secure and protected at all times. For example, active records are kept in areas where only authorized health care practitioners have access, and records are stored in locations where heat, water, fire, or other damage is not likely to occur. The hospital implements processes to prevent unauthorized access to electronically stored information.

Measurable Elements of UNC-MI.4

1. Records and information are protected from loss.
2. Records and information are protected from damage or destruction.
3. Records and information are made accessible to the patient and family upon request.
4. Records and information are protected from tampering and unauthorized access or use.

Standard UNC-MI.5

The medical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, and to document the course and results of treatment[14].

[13] United Nations Retention Schedule for records of Short-Term UN Field Missions
[14] Medical Support Manual for United Nations Field Missions, Chapter 14, Page 207, A-F

Intent of UNC-MI.5

In order for medical staff to provide the most effective care, every patient assessed or treated in a clinic as an inpatient, outpatient, or emergency care patient must have a medical record. Information in the medical record must be as up to date as possible and contain all the patient information that is needed to provide appropriate care. The information in the medical record should be organized in a logical format, easily accessible, legible and complete.

Measurable Elements of UNC-MI.5

1. Patient medical records contain adequate information to identify the patient.
2. Patient medical records contain adequate information to support the diagnosis.
3. Patient medical records contain adequate information to justify the care and treatment.
4. Patient medical records contain adequate information to document the course and results of treatment.
5. Patient medical records contain adequate information to describe the discharge of the patient and any follow up care needed.
6. Patient medical records are organized in a logical, easily accessible format, legible and complete.

Standard UNC-MI.6

The clinic has a protocol regarding those who are authorized to make entries in the patient clinical record.

Standard UNC-MI.7

Every patient clinical record entry identifies its author and the time that the entry was made in the record.

Intent of UNC-MI.6 and UNC-MI.7

Access to information contained in the patient clinical record is based strictly on need and defined by job title and function. An effective process defines:

- who has access to patient clinical records;
- which information in the patient clinical record to which an individual has access;
- the user's obligation to keep information confidential; and
- the process followed when confidentiality and security are violated.

One aspect of maintaining the security of patient information is to determine who is authorized to obtain a patient clinical record and to make entries into the patient clinical record. The clinic develops a policy to authorize such individuals. There is a process to ensure that only authorized individuals make entries in patient clinical records and that each entry identifies the author of the entry and the

date. The policy must also include the process for how entries in the patient record are corrected or overwritten. The time of the entry is also noted, such as for timed treatments or medication orders.

Measurable Elements of UNC-MI.6

1. Those authorized to make entries in the patient clinical record are identified in clinic policy.
2. There is a process to ensure that only authorized individuals make entries in patient clinical records.
3. There is a process that addresses how entries in the patient record are corrected or overwritten.
4. Those authorized to have access to the patient clinical record are identified in clinic policy.
5. There is a process to ensure that only authorized individuals have access to the patient clinical record.

Measurable Elements of UNC-MI.7

1. The author can be identified for each patient clinical record entry.
2. The date of each patient clinical record entry can be identified.
3. The time of each patient clinical entry can be identified.

Standard UNC-MI.8

As part of its monitoring and performance improvement activities, the clinic has a clinical record review process to regularly assess patient clinical record content and the completeness of patient clinical records.

Intent of UNC-MI.8

Each clinic determines the content and format of the patient clinical record based on UN form and has a process to assess record content and the completeness of records. That process is a part of the clinic's performance improvement activities and is carried out regularly. Patient clinical record review is based on a sample representing the practitioners providing care and the types of care provided. The review process is conducted by the medical staff, nursing staff, and other relevant clinical professionals who are authorized to make entries in the patient record. The review focuses on the timeliness, completeness, legibility, and so forth of the record and clinical information. Clinical record content required by laws or regulations is included in the review process.

Measurable Elements of UNC-MI.8

1. A representative sample of active and inactive patient clinical records is reviewed at least quarterly or more frequently as determined by leaders.
2. The review is conducted by physicians, nurses, and others authorized to make entries in patient records or to manage patient records.
3. The review focuses on the timeliness, legibility, and completeness of the clinical record.

4. Record contents required by laws or regulations are included in the review process.
5. The results of the review process are incorporated into the clinic's quality oversight mechanism.